Department of Health

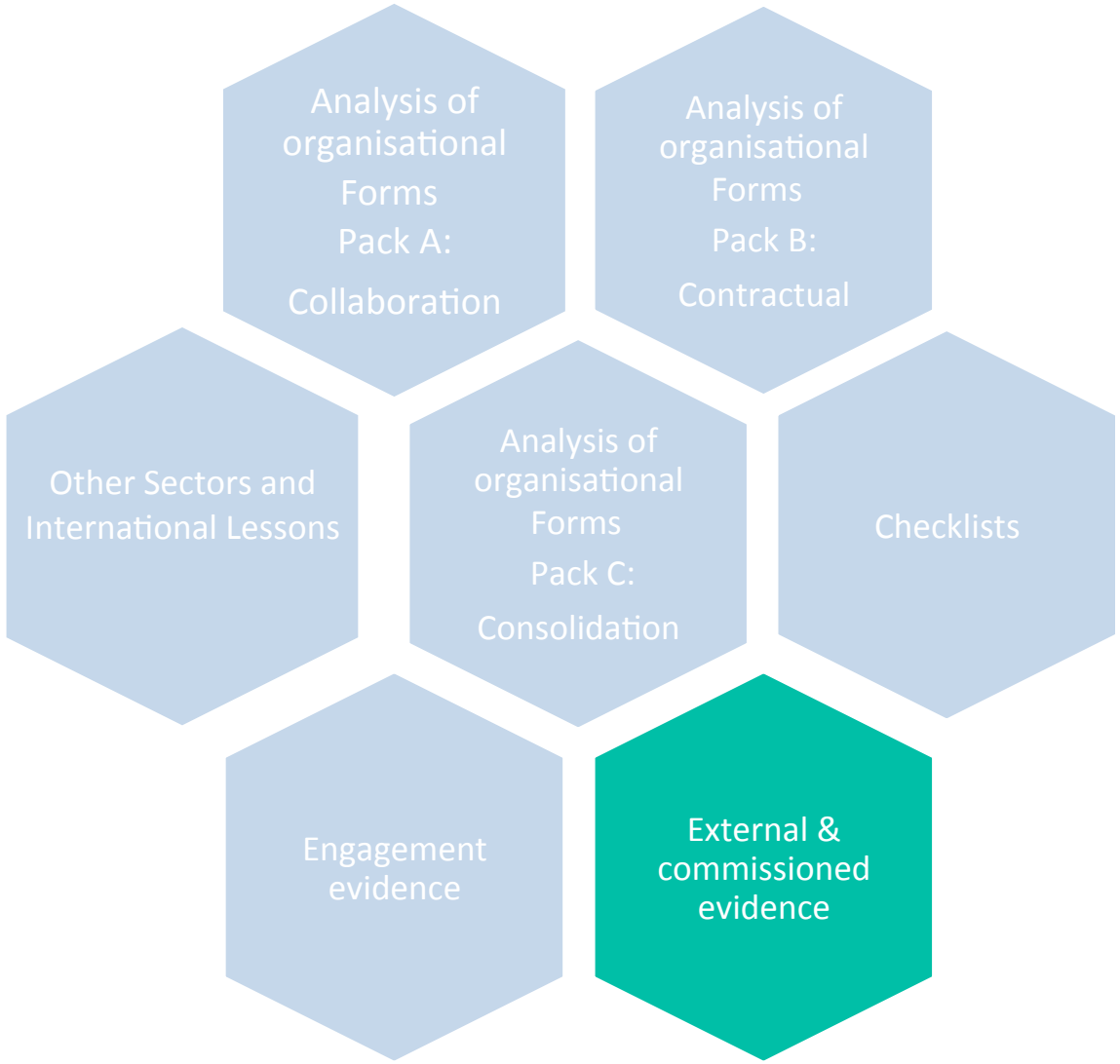
Dalton Review

Digest of key reports

December 2014

Contents

The key below outlines the supporting evidence to the Dalton Review: each pack is self-contained and can be read as a stand-alone document. This blend of evidence gathering, commissioned research and engagement feedback supports the recommendations of the Review.



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Digest of key reports

Overview

We conducted a review of published papers, grey literature and other articles relating to organisational forms in the NHS

- There have been a number of key reports that have been published by well regarded organisations over the last few months. These reports have contributed to the evidence base to support the Dalton Review findings and recommendations.
- Where we identified gaps in the evidence, we commissioned additional bespoke research to identify the key issues and to further progress the key lines of enquiry.
- This pack provides a summary of the reports, drawing out the key messages.

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Digest of key reports

Commissioned work

Buddying Review, September 2014, Foundation Trust Network

Two key pre-requisites without which buddying arrangements risk failing: 1) Developing strong personal relationships, and 2) all parties, nationally and locally, need to better understand the level of work and commitment involved for both partners.

Key messages

- Consideration should be given by national bodies, and the sector itself, to how to promote the use of buddying more widely within the provider sector, as one important means of encouraging shared learning and driving improvement.
- Clear terms of reference and timescales for achieving outputs are recommended for formal buddying arrangements, including shared understanding of the expectations between both parties.
- Buddying arrangements for Trusts in special measures should, where possible, allow flexibilities for Trusts to suggest appropriate partnerships, rather than these being imposed by regulatory bodies.
- In order to support the best outcomes buddying arrangements within the special measures regime should allow scope for local discretion, within their terms of reference.
- The cultural 'fit' of organisations should be given due prominence in setting up buddying arrangements and, in the case of special measures, all parties should have the discretion to terminate arrangements that turn out to be a poor fit or are proving unproductive.
- Any buddying arrangement, including those within special measures, should take due account of geographical proximity – both to ensure closer working between two or more organisations does not raise competition issues, and to ensure the arrangement is practically workable.
- The approach of issue specific buddying where a number of buddies provide assistance to a single organisation, should be more fully considered in order to ensure a good match between the areas of improvement a Trust in special measures has identified and the strengths of potential buddies.
- The cost implications for both the buddy Trust and a Trust in special measures need to be more robustly taken into account by the regulators so that it is at least cost neutral for those Trusts in special measures, and provides an appropriate incentive and recompense for those Trusts acting as buddies.

Commissioned work

Buddying Review, September 2014, Foundation Trust Network

Buddying arrangements

- Buddying arrangements come into being either voluntarily, usually when a senior executive make contact with a colleague with whom a relationship already exists to act as a buddy, or via a suggestion from Monitor or the TDA.
- There is a diversity of approach to 'buddying' across the NHS ranging from networking to more intensive one to one buddying most commonly used to share learning or for one party to improve their practice in a particular area.
- Those organisations that are challenged operationally may find it beneficial to select a buddy that is a good operational match and with whom they feel able to build a constructive relationship, but which is not a competitor. They should also be geographically close enough to make the practicalities of a face to face interaction work.
- It is difficult to establish the link between a buddying arrangement and improved outcomes – buddying can help make changes more rapidly, but the amount of time it can take to get buddying arrangements into place can be too long for optimal impact.

Limiting the success of buddying

- Trust and mutual respect are key requirements for a successful buddying arrangement, and cultural compatibility crucial.
- Long geographical distances can make buddying arrangements and support difficult to undertake in practice.
- The expectations of both buddies need to be managed accordingly, and the capacity of the buddies should not be underestimated – buddying arrangements can be a distraction from core business.

Potential benefits and incentives for buddying arrangements

- Pooling knowledge of good practice, sharing solutions for shared challenges. motivates buddies to improve their own organisations, providing staff development opportunities for Senior Executives.
- Often more cost-effective than hiring external consultant help.

Additionally, a flexible approach based on the needs of the individual Trust is likely to be more effective. For example, remuneration could be considered based on the type and extent of the support, and a Trust may benefit from a range of buddies with key areas of expertise in particular areas. Clarity of purpose and expectations from the buddying arrangements are important too, as some Trusts may face deep-set issues that are difficult to solve only through a buddying partnership.

Commissioned work

Provider chains: lessons from other sectors, A report for the Dalton review into new options for providers of NHS care, August 2014, Nuffield Trust

1. Operating across multiple sites requires a shift to a management system with a corporate centre and outposts, rather than appending an acquired institution onto an existing organisation.

- Management systems generally have clearly specified decisions rights at each level of the organisational structure
- Strong presumption towards a high level of devolved responsibility, within parameters and in line with the values and overall objectives of the organisation.

2. The corporate centre will have different objectives from individual business 'units' and delivering these will require different skills.

- Managerial expertise at a single-site level is more technical, and at multi-site level has an emphasis on professional development, including human resources development and motivational abilities
- The ability to take a high level view and avoid intervention, and the ability to manage across wide distances important for the multi-site managers.

3. There is generally a clear distinction between a set of tasks that are to be done centrally and a different set of tasks where individual operating units are allowed discretion, though this distinction is subject to debate.

- Tasks delivered by the corporate centre generally include governance, procurement, HR, payroll, IT, estates and property management, communications and brand management. There is usually also product development programmes and programmes for dissemination of innovation.
- Local unit tasks usually include delivering customer experience and making commercial decisions in relation to local market characteristics.
- Allocation of roles and responsibilities between centre and outposts can change over time and vary depending on circumstances.

4. The role of the operational manager at each operating unit is seen to be crucial to the success of the chain.

- They are able to ensure their unit reflects the values of the chain, and can also influence the strategic objectives of the chain, based on the local understanding of needs.

5. Running an effective multi-site organisation requires extensive standardisation of management systems and functions.

- Whilst some areas of operation are highly autonomous, products and services are usually provided in a highly systemised way.
- Template formats, design books, standardised operating frameworks, procedures and policies are used.
- Expectation is that standardised outputs are adhered to unless there is a clear and compelling reason why another approach is required.

Commissioned work

Provider chains: lessons from other sectors, A report for the Dalton review into new options for providers of NHS care, August 2014, Nuffield Trust

6. Effective multi-site organisations usually deploy significant effort in organisational development including a particular focus on talent management development

Usually significant resources are dedicated to ensuring local unit managers are supported, empowered, and well-linked with other parts of the system and peers in other units through strong lateral networks.

- Good followership is usually emphasised as much as good leadership.

7. Effective chains have clear processes in place for internal quality audit, in order to ensure compliance with governance requirements. These internal quality audit units generally operate at a national or regional level and sit within the overarching corporate structure rather than being located in operating units.

- Generally applied for ensuring compliance with statutory requirements and internal performance guidelines.
- Tend to comprise inspections by third party agencies (e.g. health and safety), site visits by internal compliance and quality audit teams.
- Intensity depends on the site – newly acquired and/or poorly performing units face much more interventionist methods, including staff rotations, imported turnaround specialists, heavy internal audit scrutiny and other methods.
- Performance monitored closely and interventionist approach taken if performance in outposts found to be lacking.

8. Successful chains have clearly defined processes for capturing, testing and dispersing innovative practice.

- Execution may differ – some chains identify particular business areas in which they seek out innovative practices, others take a reactive approach.
- Allowing individual units to innovate while capitalising on standardisation benefits a complex and difficult task.

9. Making the transition from a single site, or collection of autonomous units, to a more standardised chain operating model will require large scale cultural change. This presents a significant management challenge in its own right.

- Success achieved through maintaining a clear sense of direction and ensuring the senior team was visibly leading staff in the change.

Commissioned work

Provider chains: lessons from other sectors, A report for the Dalton review into new options for providers of NHS care, August 2014, Nuffield Trust

10. There is a high level of risk associated with transactions to add operating units. This requires a very substantial investment in due diligence and to integrate units. Caution is required about any policy which reduces the incentives to assess risks correctly.

Ways to support NHS organisations exploring possible chain arrangements: Careful consideration of the risks facing each organisation as a result of any transaction or different working arrangement is required. High quality due diligence must take place, and if the decision is positive, a detailed implementation plan needed. Organisations must be permitted to decline to enter any arrangements. Clarity and transparency around aims of all parties required. The decisions taken are context specific so formal decision aids may not represent best value. Case by case support is likely to be needed, focusing on the specific circumstances.

Commissioned work

The changing hospital landscape: An exploration of international experiences, RAND Europe (July 2014)

- Spending on inpatient care constitutes a major expense in most OECD countries, ranging from one-fifth to a quarter of total current health expenditure in countries such as Canada and Spain and almost up to 40% in France and Greece (2011).
- As the nature and scope of hospitals vary across countries, so does the way hospital care is governed, organised and financed. At the same time, common trends can be observed such as the move away from centralised control towards the introduction of a greater degree of institutional autonomy and the use of market incentives.
- Many countries have also departed from the traditional approach of using global budgets for paying hospitals towards introducing activity-based funding. While this move was largely driven by a need to enhance overall efficiency, specific objectives varied by country:
    - Germany sought to reduce excess capacity in the hospital sector;
    - France and Italy aimed to harmonise payment mechanisms for public and private providers.
- Evidence suggests these macro influences has been associated with changes in the structure of hospitals and a growth in hospital groups, chains and networks.
- Some countries such as Australia and Ireland have been pursuing policies for the mandated formation of multi-hospital networks or groups.
- There is an expectation that the formation of such groups and networks will lead to greater market influence, economies of scale and scope, reduced duplication of resources, more effective training and improved efficiency in the provision of services, among other motivations.
- Hospitals are classified according to legal status or ownership, distinguishing public from private ownership, with France, Germany and the US further differentiating private non-for-profit and private for-profit hospitals. In these countries, hospitals in the private sector have traditionally contributed to delivering publicly funded healthcare services, although the relative contribution varies. Private hospitals in England are distinct from the publicly funded sector.
- There are a number of similarities in the trends of hospital provision in the different countries and these are broadly reflective of trends observed in England. For example, the number of inpatient beds and length of stay have declined.
- There is a broader trend towards the creation of hospitals groups or chains and multihospital networks, particularly in the US but also in EU countries. The degree to which ‘hospital groups’ or equivalent are formally defined varies by country. For example, in the US, a ‘hospital system’ can be multihospital or a diversified single hospital system.
- In Germany and the US over 60% of hospitals are now part of some form of partnership, system or network. It was felt that increasing consolidation and formation of hospital groups were likely to continue.

Commissioned work

The changing hospital landscape: An exploration of international experiences, RAND Europe (July 2014)

- Overall, RAND observed an increasing trend towards privatisation and concentration in three of the countries reviewed, France, Germany and the US.
  - In France, this has occurred through closure of private hospitals and greater concentration of services in larger hospitals to improve quality and safety.
  - In the US, economies of scale are thought to be one of the drivers for consolidation but market forces and the greater negotiating power that comes with increasing market share has also been as important driver.
  - In Germany, there has been a trend towards cooperation and consolidation of hospitals, driven mainly by a combination of financial pressures, regulatory efforts to enhance quality and safety through the introduction of minimum volumes and the need to compete for patients in a market characterised by oversupply.
  - Ireland is currently likely to result in the formation of hospital groups, each with a unified governance structure with the vision that hospital groups will see the centralisation of high risk to larger centres.
- In the context of consolidation and financial pressures, it was noted that public hospitals found it particularly challenging to raise capital compared to private (for-profit and not-for-profit) hospitals.
- The evidence of the effects of hospital consolidation is not clear-cut. Hospital groups or systems that are managed by a single legal entity may be more successful in achieving efficiency gains and improvements in the quality of care than hospital networks that are formed through strategic alliance or contract agreement but this is likely to depend on the context within which they operate.
- Hospital consolidation may lead to quality improvements as increased size allows for more costly investments and the spreading of investment risk.

Commissioned work

Credentialing providers to take on additional responsibilities: An analysis of the evidence & stakeholder views, The King's Fund (September 2014)

The report investigates how and in what circumstances an organisation could be pre-approved as suitable for the Dalton Review organisational models, particularly for chains and franchises, focusing on the criteria and the process of the credentialing.

Purpose of credentialing

- There are a number of problems credentialing can help solve:
  - making voluntary associations between hospitals easier, quicker and less bureaucratic
  - reducing duplicative processes for each potential transaction
  - creating new forms of reward and recognition for the best-performing providers
  - narrowing the field and screening out organisations that lack the necessary capabilities to be involved in new organisational models
  - creating a process that is developmental in its own right.
- What is deemed most important should shape the design of the credentialing process.
- Two alternative methods for credentialing: 1) Preliminary stage in a formal procurement process – i.e. as a framework designed to simplify subsequent stages of major transactions between organisations, or 2) recognising success – akin to a 'kitemark'. The report focuses on the former.

Scale and scope of transactions for which credentialing could be most beneficial

- Credentialing process – as a formal procurement process, is most useful in those organisational forms where there is a change of management contract – service-level chains, multi-service chains and management/operational franchises. Other organisational models are based more on willingness to partner and adding a layer of monitoring would inhibit entrepreneurial activity.
- Credentialing process as a 'kitemark' is potentially also useful for other organisational models.

Commissioned work

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How would credentialing relate to transaction-specific processes?

- Credentialing should be kept light and based as far as possible on existing measures (e.g. CQC assessments, staff survey data). Robust transaction-specific assessment would still be necessary, as the transactions are complex and heterogeneous. Additionally, credentialing works best as a method keeping out the most unqualified providers, rather than as a guarantee of quality – this would also suggest that a streamlined approach to credentialing would be most appropriate.

Which types of organisation could be credentialed?

- In principle any. In designing a credentialing process it is important to ensure that the assessment criteria do not unfairly disadvantage one sector over another (NHS / IS or acute Trusts / other providers). The assessment criteria should set the bar sufficiently high – particularly with regard to prior experience – but also leave a pathway open for new entrants.

Potential assessment criteria

- The most important assessment criteria can be categorised as: leadership, organisational culture, people management and staff engagement, improvement capacity and methodology, innovation, governance, quality and financial performance, partnership working and system leadership, track record in mergers and acquisitions or turnaround.
- Across all areas, the critical part of the assessment should focus on understanding the degree of transferability to a new organisational context. This adds up to an assessment of the transferability of an organisation's operating model – which will be key in the context of building chains or franchises.
- The assessment criteria might vary depending on the scope of the transaction (e.g. comparing whole-organisation to service-level changes) and as per according to the type of provider – for example, it may be that the full suite of assessment criteria is not needed for providers that have already achieved Foundation Trust status as other checks and balances exist.

How a credentialing process might be conducted in practice

- Any credentialing process should avoid duplication and should, as far as possible, build on and align with existing assessment frameworks used in the NHS, such as the assessment frameworks used by Monitor, CQC and the TDA.

Commissioned work

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Risks

- There are some risks emerging from credentialing and adding a new layer of monitoring into the process. These are:
  - Detracting from the robustness of transaction-specific assessment, failing to reduce bureaucratic burdens, misreading market appetite, creating a redundant process, inhibiting innovation, credentialing the 'wrong' providers, losing clarity of purpose.

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Digest of key reports

Digest

State of Care 2013/14, Care Quality Commission (1)

Caring for people with dignity and compassion, good engagement, strong and open leadership, meeting the challenges of tighter funding and responding to failures in care quality common themes driving change across health and social care.

Implementation of the Health and Social Care Act 2012 has changed the way primary care, NHS services and public health services are paid and commissioned. The split of budgets between different commissioning organisations with different roles and geographies has started to have an impact on the relationships and agreements at local and national level including redesign of services.

The care provided by health and adult social care providers suffers from a level of variation in quality that should be widely acknowledged and addressed. There are big differences in the quality of care people receive from different providers, across different geographies and even at different times of the day or week, unexplained by warranted factors such as differences in local needs.

Variation in basic safety is a concern – particularly a lack of effective safety processes underpinned by culture that learns from mistakes and near misses. The principle of keeping people safe from harm is fundamental.

Leadership is important – Leadership and culture have a significant impact on other areas of quality, and good leadership, at all levels of the organisation, shapes its culture into one where service users and the quality of their care is a priority.

CQC seeks to reduce variation and encourage improvement through:

- Developing new methodology for inspecting and regulating services across health and adult social care
- Increasing intelligent transparency through “Intelligent Monitoring” tool
- Encouraging a learning culture in health and social care
- Requiring and encouraging improvement on behalf of people who use services

Digest

State of Care 2013/14, Care Quality Commission (2)

There is clear variation in the quality of care in NHS acute hospitals. There is variation between hospitals, within hospitals and even within the core services provided by each hospital. CQC asks the five key questions in each inspection – are services safe, effective, caring, responsive to people's needs and well-led?

Acute health providers (and mental health and community health services) should:

- Be open and use CQC assessment as a positive driver to improve services for the people that rely on them
- Make safety a priority and build a safety culture
- Maintain the momentum of change following the Francis Inquiry
- Recognise and invest in leadership, from Board level to the ward
- Listen and act on feedback from staff and patients
- Champion all the care needs of patients and help draw together a package of care around them

NHS England, Clinical Commissioning Groups, Monitor, NHS Trust Development Authority, trade bodies and other organisations in the system should:

- Embrace greater intelligent transparency, particularly around understanding effectiveness
- Use CQC judgements fully
- Encourage safe innovation
- Have the courage to tackle failure and complacency
- Understand and discharge their own responsibilities for improving the quality of care

Digest

Big Med, The New Yorker, Aug 13, 2012, Atul Gawande (1)

The medical field: Medicine tries to deliver a range of services to millions of patients, at a reasonable cost and consistent level of quality. But the costs are soaring, the service mediocre and quality unreliable. The rates of failure and complication for a given service can vary by a factor of 2 or 3, even within the same hospital, because all clinicians have their own way of doing things. It takes a long time for medical developments to become widely used on majority of patients – average 15 years.

The Cheesecake Factory restaurant chain: Delivers affordable and consistently high-quality food at all chain restaurants. It has an assembly line of making the food. Detailed instructions given for ingredients and objectives, but rest left to tacit knowledge. Each dish inspected and rated by a manager. New menu items regularly, with implementation in few weeks. Uses historical data to do "guest forecasting" – determining how much staff and food to purchase to minimise waste. Standardises processes and reviews them regularly.

Key question and thesis: How can innovative medical procedures be designed so they can be delivered affordably to masses? The field of healthcare should look at best practices, standardise them, and bring them for all to execute. This would be the equivalent of Cheesecake Factory in healthcare.

An example of standardisation: Brigham and Women's Hospital, John Wright and standardisation of joint-replacement surgery.

A group of specialists – surgery, anaesthesia, nursing, physical therapy – examined details, reviewed academic literature and used consensus to come up with a standardised process. Fixed standards for anaesthesia and post-operative regime. Limited the models of prostheses used to three lowest-cost knee implants (as all established, cheap and expensive, models had similar failure rates). Used behaviour science to push changes: staff allowed to order non-standard implants and post-operative regimes, but surgeons have to enter treatment orders in the computer themselves and show performance superior / price at least as low. Have encountered staff resistance - half of surgeons approve, half barely tolerate, 1-2 hostile.

Successful model: Now surgeons use a single manufacturer for 75% of implants, giving hospital the bargaining power to bring cost down (knee-implant costs slashed by half). Start-to-finish standardisation led to better outcomes – the distance patients could walk two days after surgery increased from 53 to 85 feet, amount of narcotic pain medication required fell by a third, could leave the hospital on average one day earlier (saving $2000 per patient).

Digest

Big Med, The New Yorker, Aug 13, 2012, Atul Gawande (2)

Other examples of standardisation: The Virginia Mason Medical Center, in Seattle, knee surgery and cancer care; the Geisinger Health Center, in Pennsylvania, cardiac surgery and primary care; the University of Michigan Health System blood transfusion process.

An example of quality control / performance monitoring – ICU tele-operations in Steward's hospitals

- A team of doctors and nurses, man a tele-ICU unit, a remote control centre that allows them to remotely monitor patients and contact doctors/ nurses on-site.
- Live feeds of monitor readings, access to scans and laboratory results, HD video cameras in patient rooms, allowing them to speak to staff and patients, software alerting concerning patterns
- Deal with clinicians, trying to get them to agree on precise standards of care and making sure they follow them. Have a reference list of standards agreed with ICU leaders, and check if it is being followed. Rather than a command control approach, negotiation and offering assistance works better with tele-ICUs. Tele-ICU doctors have the authority to enter orders, but on-site physicians have the final say.
- Have tried introducing the command centre team, visiting hospitals, bringing doctors/nurses to the tele-ICU centre, but still experience staff resistance.
- Tele-ICUs have improved costs and outcomes, and increased better practices (in over 250 hospitals across US). However, in some places strong staff resistance to tele-ICUs – see them as strangers checking their work. Several hospitals have decommissioned their systems, clinicians blocking/breaking cameras, asking videocameras to be turned off as distracting to patients.

Main conclusion: Healthcare should move from small and independent to larger size and centralised control – the latter has more benefits. Best practices should be standardised and quickly brought in for the majority to use, and centralised control would enable this to happen. There are dangers to hospital chains – they may create monopoly positions that suppress innovation and drive up costs over long term. Strong public oversight required to make Big Med work, and governments need to enact rules on transparency, limit some activities and break up monopolies.

Digest

How not to fix US health care – Copy the Cheesecake Factory, Forbes, Aug 13 2012, Steve Denning (1)

Big Medicine article argues that hierarchical bureaucracy in Cheesecake Factory model is the best prospect for change in health care. But hierarchical management does not work in healthcare or other knowledge based professions, and standardisation approach ignores that US healthcare is a collection of different problems.

Four fundamental flaws of the Big Med article:

1. Wrong question
2. Wrong knowledge model
3. Wrong management model
4. Wrong conclusions about scaling

Wrong question: There are three basic models in healthcare. 1) Solution shops, where you have skilled experts solving unstructured problems, 2) value-adding processes, where problem and solution is known, and value added in the process (knee repair operation), and 3) facilitated networks of people working with each other (e.g. community-based approached for diabetes). Asking whether Cheesecake Factory or any other model is the right one for US healthcare is wrong, because it fails to appreciate that US healthcare is a collection of different problems that need different models.

Wrong knowledge model: Basic assumption of hierarchical bureaucracy does not work in health care. The managers know less of what patients need than the doctors and nurses and imposing directives from above works poorly as instructions are often wrong and workers become dispirited.

Wrong management model: High-end knowledge work like software development, and hierarchical management works badly, as developers know more about software than managers. Thus self-organising teams closely linked with customers work better – hierarchical Cheesecake Factory model will not work.

Wrong conclusions about scaling: Size brings more bureaucracy and more hierarchy. A small and highly-specialised facility may be more efficient, than large, inefficient organisations brought together.

Digest

Seizing the opportunity: FTN lecture by Rt Hon Alan Milburn: ten new perspectives from healthcare leaders (2014), FTN (1)

9 key themes:

1. **Provider autonomy sits at the heart of the FT concept;** Independence from state control a key driver, but autonomy also means FTs need to move away from financial dependence.
2. **Local accountability also sits at the heart of the FT model;** Strong emphasis on accountability to local stakeholders important and enhances work on macro and micro level.
3. **FT model has enabled a range of innovations benefiting patients;** There has been a change in priorities from meeting financial and political targets to improving patient safety, outcomes and experience.
4. **Success has been accompanied by a sense of, as yet, unfulfilled promise;** Whilst broadly the FT model has been successful, there are still questions over local accountability, performance variability and excessive regulation restricting FT freedom. FT model also needs to change in order to accommodate the changing NHS.
5. **Excessive regulation has eroded the FT model;** The sense of autonomy is lost, but due to recent FT failures regulators have become more risk-averse.
6. **FTs need to become more effective system leaders.**
7. **Enabling greater provider collaboration and consolidation;** In a situation where provider clinical and financial sustainability is under increasing pressure, this is crucial. On the concepts of management chains – if the best providers earn the right to lead chains, they might work in FT setting, but the danger is that when standardisation increases, the localism and local accountability of FTs decreases.
8. **Reversing the tide of increasing regulatory involvement;** Taking measured risks is important, whilst balancing the fact that struggling providers need to be helped to stop them from becoming serious problems.
9. **Clarity is needed on the future of the FT pipeline;** The conversion from NHS Trust to FT needs to be speeded up, but bar should not be lowered, otherwise there will be problems with low-quality FTs. Instead of expecting all NHS Trusts to become FTs, one option would be to group non-FTs into organisational groups or chains.

Digest

Seizing the opportunity: FTN lecture by Rt Hon Alan Milburn: ten new perspectives from healthcare leaders (2014), FTN (2)

Key issues from different perspectives:

Alan Milburn (former secretary of state for health): There should be no preferred providers in UK, either public or private, but should choose the best in quality and efficiency. Next reforms should focus on creating a legal environment that allows competition and subjects competitors to the same standards and incentives. Alzira (Spain) particularly interesting model, where a community of patients looked after under a single capitation-based contract. Providers are paid according to outcomes, with incentives to keep people healthy and out of hospital. Profits for the private providers are capped. If patients choose to seek treatment elsewhere – e.g. if the quality or timeliness of local services is poor – providers face financial penalties. Competition and collaboration, have enabled capped costs and improved outcomes.

Stuart Bell (Chief executive, Oxford Health NHS Foundation Trust): It was thought FTs would form chains around the country but this has not happened. This is probably because healthcare is more complex and fundamentally rooted in local networks and geography than was thought, even in highly specialist tertiary care. Alzira or Kaiser integrated network provision models, are a good point to start to develop a model of systemic care to a population with some degree of geographical footprint.

Dr David Bennett (Chief executive, Monitor): The priorities of organisations shouldn't be on becoming an FT, but on delivering innovation and good patient care. Monitor should be flexible on business models to enable this. Particularly important factor is the organisations capacity to change, to learn and develop, not just the leadership capability. Quality governance, and governance of planning, performance improvement and organisational development are other metrics that show the organisational capacity to change. The Trusts need to have good processes, an understanding of their capability to change and handle uncertainty, and research the expected changes and what other providers are doing.

Digest

Seizing the opportunity: FTN lecture by Rt Hon Alan Milburn: ten new perspectives from healthcare leaders (2014), FTN (3)

Nigel Edwards (Chief executive, Nuffield Trust): There have been two main ideas – that FTs are embedded locally, with local accountability, and that freeing FTs from central control can improve their governance as they have to develop devolved decision-making. The third idea emerging is that chains and the standardisation of processes and quality may give economies of scope and scale.

The problem with the chain model is the loss of locality. There are many models for chains, from networks that have local community members on boards to networks that mainly share resources, such as back office support and IT, to systems with centralised decision making. However, some decision rights will always be sacrificed in a chain structure. There have been different ways of setting up hospital chains in different countries. In Germany they are relatively straightforward acquisitions of troubled hospitals. In Poland the hospitals were just made all independent, and this led to problems in financially troubled Trusts. In Spain in Alzira, a hospital was set up as a head of a local health system.

Alastair McLellan (Editor, Health Service Journal): Management chains can work within the FT model ethos, if it is the best providers that earn the right to lead chains. This could help also with the leadership challenges – the right skill-mix in terms of experience, knowledge and robustness is relatively rare, and unlikely to exist cover all 243* NHS organisations. Maybe around 50 people do have the right skill set – these people could run the chains and grow new talent under their protection and tutelage.

Tony Thorne (Chair, South East Coast Ambulance Service NHS Foundation Trust): In large companies with many operating units, the central team contributes the best if it sets overall goals and strategy, checks that local plans implemented successfully and ensures local leadership capability. Managing issues from the centre more problematic as identifying a local operation's problem and providing a solution to it are difficult. In similar terms well-led FTs are likely to arrive to better decisions than if these decisions were driven centrally.

* Number correct at the time of the lecture

Digest

Facing the future: smaller acute providers, Monitor (June 2014) (1)

- Among acute NHS Foundation Trusts smaller providers tend to be more financially challenged. Trends in EBITDA% (Earnings before interest, taxation, depreciation and amortisation as a percentage of operating revenue) for FTs showed greater falls in EBITDA% for smaller Trusts over the past four years and there were examples of smaller Trusts in significant financial difficulty, with EBITDA% below 2%.
- 'Smaller' providers defined as operating revenue (income) under £300million in 2012/13 FY. These represent over half of the acute non-specialist providers operating in the NHS in England and one third of all inpatient spells.
- Hospitals in England tend to be larger than those in the rest of Europe. The hospitals considered smaller in England would be seen as relatively large in other countries.
- The empirical analysis finds limited evidence of a size effect and size appears to explain only a small amount variation in financial performance. This suggests that, whilst size, or factors that are correlated with size, may be increasingly important, there are likely to be several other factors that are important in explaining financial performance.
- Most of the variation in performance cannot be explained by factors that can be easily identified and measured. Such factors include 'softer' drivers such as the relationships among different players in the local health economy or the quality of leadership at the provider.

Digest

Facing the future: smaller acute providers, Monitor (June 2014) (2)

- These findings suggest that providers already facing financial issues will not necessarily resolve them simply by increasing scale in their existing services, for example through merger. It is likely that these current problems are being driven by issues other than scale.
- The empirical evidence does show some other aspects of a provider's structure that were likely to affect financial performance, though they did not seem likely to disproportionately disadvantage smaller providers. These include:
    - The number of A&E sites a provider operates – strong evidence that operating multiple A&E sites has a negative impact on financial performance.
    - The number of consultant specialities – some evidence that those providers with more consultant specialities have worse financial outcomes.
    - The share of clinical income from tariff services – providers with a higher share of their income coming from tariff services tended to perform worse financially.
- A number of current trends such as 24/7 consultant delivered care and moving care out of hospitals are more likely to present challenges to smaller providers.
- The review notes that many providers are working hard to adapt and find opportunities by re-thinking their business models to gain additional value, efficiency or improved patient outcomes through networks and partnerships with other providers.
- On balance, the review suggests that smaller acute providers in all health economies will have to adapt fast to meet the pressures facing the sector as a whole. However, in many health economies they could have an important and sustainable place in the future provider landscape.

Digest

Future organisational models for the NHS: Perspectives for the Dalton review, The King's Fund and FTN (July 2014) (1)

A number of common themes emerge from the report:

- There is no single organisational solution for Trusts in the NHS, but instead a wide range of models. Rather than a single centrally imposed model, a localised, 'horses for courses' approach will allow providers to choose the organisational structure that works for them, their community and their local health economy. Ensuring robust governance, and promoting the dual concepts of local accountability and earned autonomy from state control should remain at the heart of any provider organisational model.
- A number of options are available, many of which are already in operation at service level within Trusts. These include buddying successful providers with those in difficulty, franchising the management of NHS hospitals and services to private sector organisations, creating networks and alliance of providers, and enabling high performing organisations to take over struggling providers. While there is some experience in the sector and further afield to support the use of all these options in different contexts, some of the evidence is limited, and much depends on how they are implemented in practice. There is no evidence as yet that one approach is demonstrably superior to the rest.
- The evidence suggests that most of the organisational arrangements described could help drive improvements in quality of NHS services. The evidence finds common success factors across all the different models are good working relationships and a strong, common focus on quality improvement, with measurable means of achieving that improvement.
- The impact of different organisational models depends critically on the skills of the leaders involved and their ability to bring about the changes in culture and behaviour on which sustainable improvements in performance depend. There should be consideration as to how to build up new types of leadership capacity within the sector to lead different organisational forms.

Key issues from different perspectives:

- **Chris Ham:** The impact of different organisational models depends critically on the skills of the leaders involved and their ability to bring about the changes in culture and behaviour on which sustainable improvements in performance depend.

Digest

Future organisational models for the NHS: Perspectives for the Dalton review, The King's Fund and FTN (July 2014) (2)

- **Chris Hopson**: Greater collaboration, co-operation and, where necessary, consolidation between providers will often be part of the solution. He argues that providers – in consultation with their communities, partners and commissioners – should be free to choose whatever organisational structure best meet the needs of their local population.
- **Brad Stoltz, Tenet Healthcare Corporation:** The largest benefit of operating as a large, multi-hospital system is the ability to make investments that single hospitals or very small chains cannot afford to make. For example, investing in technology and systems to support clinical operations and quality as well as labour management. The geographic spread and size enables the identification and diffusion of new ways of delivering services. ***'The value of being part of a larger chain is that you don't have to solve everything yourself. You're not in it by yourself, you're in it together, so you can come up with a better solution and a better approach by pooling resources and thinking collectively.'***
- **Jonathon Fagge, Norwich CCG:** The biggest challenge with chains is how to maintain the uniqueness of a Trust and preserve the sense of being firmly rooted in and answerable to locality.
- **Dr Anthony Marsh, West Midlands and East of England Ambulance service:** Whatever governance arrangements and strategic leaderships you design, you always need local leadership capable of delivering bespoke services to meet the local population's needs. Need to manage strategic risks by having best people in most challenging roles.
- **Lucy Heller, ARK Schools: I**n practice there are things that chains can work well for health, for instance chains can develop people, creating career opportunities across a network in a consistent way. They can commit the level of investment needed to have really good training and recruitment. Health chains can still be tailored to local needs and locally accountable within a wider governance model. This is how it works in schools.
- **Mike Deegan, CMFT:** CMFT have a well-established group structure in which the board sets the overall corporate direction, but the vast majority of service delivery is devolved to individual hospitals. Scale enables to look at the support and back-office functions centrally to ensure efficiency is driven between hospitals. Also see significant improvements ward staffing levels and address longstanding recruitment and retention issues, as staff rotate across sites. One of the disciplines consolidation brought was to codify and catalogue all existing clinical pathways and protocols more effectively.
- **Andy Brogan, South Essex Partnership University FT:** In 2010, SEPT acquired Bedfordshire and Luton Mental Health and Social Care Partnership NHS Trust, despite not being geographically adjacent. There are challenges in running a wider geographic dispersed organisation. Invested in technology, especially video conferencing to reduce travel times and keep people connected. Nevertheless, have benefited from standardising clinical and quality standards across different sites. Need to be pragmatic and flexible and exploit strategic opportunities to share premises and back-office function.

Digest

Improving NHS Care by Engaging Staff and Devolving Decision-Making: Report of the Review of Staff Engagement and Empowerment in the NHS, The Kings Fund (July 2014) (1)

- The quality of care depends on the skills, commitment and compassion of staff.
- Levels of staff engagement, as measured by the annual NHS staff survey, are increasing, although wide variation exists across the NHS.
- There is compelling evidence that NHS organisations in which staff report that they are engaged and valued deliver better quality care. Superior performance is evident in lower mortality rates and better patient experience.
- Evidence from the NHS survey shows that FTs outperform NHS Trusts on staff engagement but the differences between the two types of organisations are marginal and have not changed over time.
- There is emerging experience that many of the staff-owned and led public service mutuals in the NHS are improving levels of engagement among their staff, and that is bringing benefits, including reducing absenteeism and staff turnover.
- There is a role for leaders to play. Leaders and mangers at all levels within the NHS hold the keys and typically success lies, in a sustained effort to embed the right behaviours, ways of working, and values throughout provider organisations.
- The Boards of NHS organisations must lead the process and show through their words and actions that staff engagement is a high priority.
- Empowering frontline staff – devolve both accountability and decision-making to staff whether related to improving quality, addressing safety concerns or responding to financial challenges.
- In devolving responsibility, many providers invested in staff through leadership and management development and training in areas such as quality improvement skills and methods.
- Staff in mutuals delivering NHS services tend not to hold substantive financial stake in their organisation or necessarily receive a share of profits. Nevertheless, it is evident that many feel a powerful sense of psychological and emotional ownership of their organisations.

Digest

Westminster Discussion No. 4, Series 12, NHS Trust Mergers: Where have we got to? (Monday 9 June 2014) (1)

- There are widespread fears that in 2015 significant numbers of Trusts will encounter problems in both service quality and financial sustainability.
- Few in the NHS understand the regulatory regime around competition and choice.
- Competition is regulated to protect and promote the interests of consumers – in this case patients. Regulation endeavours to balance any loss of competition against benefits from service improvement. The CMA believes that, since patients' interests are at the heart of what it does, there is no fundamental reason why there should be conflict between its decisions and the views of health professionals.
- Internationally, evidence indicates that between two-thirds and three-quarters of mergers fail to deliver what they promised. Some mergers are driven by short-term factors, others by the egos of chief executives. They can be undermined by poor strategic insight and weak implementation.
- Since the Health and Social Care Act 2012 the CMA and its predecessors have reviewed four NHS mergers. One – Bournemouth and Poole – was blocked because the regulator decided there was not compelling evidence that patient benefits would offset the reduction in choice.
- The rejection of Bournemouth and Poole and the time it took – 10 months – led to discontent with the competition process. Trusts find it complicated and cumbersome. Drawn out processes risk haemorrhaging managerial and clinical talent. Legal costs are high; the experience of Bournemouth and Poole and other proposals indicate the Trusts can expect total bills of around £3-6m or more.
- The benefits of merger include the quality and efficiency benefits of concentrating services, the advantages of building larger clinical teams, synergies in administration, reducing excessive fragmentation and eliminating excess capacity.
- One of the most important benefits cited is the opportunity to share the expertise of high performing leaders. In theory, it should be possible to share leadership expertise without having to merge, but in practice this has proved hard. For example, managing two groups of clinicians across two Trusts is more difficult than having one group under a unified leadership team.

Digest

Westminster Discussion No. 4, Series 12, NHS Trust Mergers: Where have we got to? (Monday 9 June 2014) (2)

- Implementing a merger is a huge management challenge which needs robust planning to get the structure, systems and culture in place to deliver the promised benefits.
- Leadership is a decisive factor in implementation; a team which is good at running a Trust day-to-day may not have the skills to deliver a merger. Unlike the private sector, the NHS is unable to provide the financial rewards to lock good managers into a merged Trust. There is also the opportunity cost in management time.
- There are overlapping and possibly contradictory processes running simultaneously, with Trusts being challenged by one part of the system whilst being bailed out by another.
- Mergers are not the only solution. Other options include establishing chains of hospitals, sharing senior managers, vertically integrating services and closure.
- The fact that some hospitals regarded in this country as small and unviable are quite sizeable by international standards raises awkward questions about why smaller DGHs are under such pressure – is it simply the result of a dysfunctional payment system?
- Does the NHS need a competition regulator? Applying rules used for mobile phone operators and payday loan companies to a state-funded health care system can seem perverse, and disproportionate to the modest role that competition and choice play in patient care. There has to be doubt about whether this is the most appropriate way to make decisions about the NHS.
- Oversight of the NHS by a competition regulator is set to continue as long as competition and choice are used to improve services.
- In a stressed financial climate, devising and implementing a merger is a hugely risky and costly endeavour. Since more mergers fail than succeed in achieving their objectives, oversight must be rigorous and testing.
- There is confusion about the respective roles of the CMA, Monitor, TDA and commissioners in supporting or challenging distressed Trusts, and about where competition and choice fit into the overall priorities of the NHS, including its financial sustainability.

Digest

Michael West (2014), Developing cultures of high-quality care, Lecture Michael West et al. (2014), Delivering a collective leadership strategy for health care

LECTURE: Six key areas**:**

1. Communicating an inspiring vision: inspiring in practice, behaviour and in terms of articulation, and it must be enacted as priority.
2. Translating the vision into objectives – these need to be clear and aligned with the objectives of organisations, departments and teams. They also need to be challenging to create motivation, measurable to enable performance feedback and limited in number to max 6-7, to avoid confusion.
3. People-management shapes the culture – there is a strong positive link between staff wellbeing and satisfaction and patient experience. Staff management and the recruitment process create a message of the culture and values of the organisation, making people-management the second most important way to affect organisational culture, after leadership.
4. Engaging staff and continual learning – research shows that staff engagement predicts the performance of NHS Trusts, and that command and control cultures adversely affect high-quality care. Involving staff in problem-solving and decision-making creates high-performance culture.
5. NHS needs “real teams” – real team-working incorporates clear objectives, working closely together to achieve those objectives, and regular performance reviews. Research suggests 5% more staff in “real teams” translates to a 3% drop in mortality rates. 91% of NHS staff work in teams, but only 40-41% in “real teams”.
6. Core values needed in human communities: learning, courage, justice, humanity, prudence and gratitude.

Article:

NHS needs collective leadership to overcome challenges.

Collective leadership is sharing responsibility of leadership by all members of the organisation, and the “distribution and allocation of leadership power to wherever capability, expertise and motivation sit.”

Current leadership development in NHS is individual-focused, overly generic and not transferable. Learning focused on the individual will not transfer into collective leadership. Collective leadership requires a new collaborative mind-set and for the leadership team to empower all staff as leaders.

Contents

Digest of key reports

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