The King's Fund

Ideas that change health care

# Credentialing providers to take on additional responsibilities:

# An analysis of the evidence & stakeholder views

September 2014

## Contents

# 1. Introduction

## Terms of reference

The Dalton review is looking at a wide range of organisational and other options to enable "the best care found in successful NHS trusts to be extended to those hospitals who experience difficulty in meeting standards for patients". This includes:

- Locality based federations
- Joint ventures
- Service level chains
- Management/operational franchises
- Multi-service chains
- Vertically integrated care organisations

We were asked to investigate what would be the success criteria such that an organisation could be pre-approved as suitable to enter into one of the above models.

**In this report we focus on models which would involve a change in management control – specifically chains and franchises – for reasons set out in section 3.**

## Our approach

Our research involved three main components:

- A review of the literature on mergers and acquisitions, chains and franchises in the health sector and more widely
- Semi-structured interviews with 21 experts from a range of perspectives, including the NHS, private sector healthcare organisation, Academy schools, and key individuals from the health policy and research communities
- An expert seminar to test and validate emerging findings

## The report

This report investigates the criteria that could form part of a credentialing process as well as how that process might be conducted. In particular, we address questions regarding the purpose and scope of credentialing, and the relationship with existing transaction processes and assessment frameworks. We also explore a number of risks that would need addressing if a credentialing process was introduced.

In the process of conducting the research it became clear that there are also a number of broader issues that relate to the idea of using chains and franchises in the health sector, which could present barriers regardless of whether or not a credentialing process is introduced. These include concerns regarding the following:

- Limited incentives for high-performing organisations to take on management responsibility for challenged trusts
- The merits of using organisational solutions to what may be more deep-seated health economy- or NHS-wide problems
- The large number of challenged trusts relative to the number of high-performing trusts potentially capable of taking on extended management responsibilities

We refer to these wider issues briefly in sections 8 and 9 of this report, but consider an in-depth treatment to be outside the scope of this piece of work. We are aware that some of these issues are being examined separately as part of the wider Dalton review process.

Our remit did not extend to making a recommendation regarding whether credentialing as an idea should be pursued or not. However, we did encounter some significant scepticism and grounds for caution, and this is reflected in sections 8 and 9. An important question here is what the purpose of credentialing is intended to be – since the relevant set of concerns depends on how credentialing is conceived and designed. We address this question in the following section.

## 2. What is the purpose of credentialing?

There are a number of overlapping problems which credentialing has been positioned as a potential answer to. While several of these issues are inter-related, credentialing could be designed and implemented in quite different ways depending on which of the following is understood to be the primary purpose. Certainly it should not be assumed that a single process can satisfy all of these aspirations simultaneously:

1. Making voluntary associations between hospitals easier, quicker and less bureaucratic
2. Reducing duplicative processes for each potential transaction
3. Creating new forms of reward and recognition for the best-performing providers
4. Narrowing the field and screening out organisations that lack the necessary capabilities to be involved in new organisational models
5. Creating a process that is developmental in its own right

The last of these in particular requires some elaboration. It was clear from our interviews that there is a significant difference between managing a chain or franchise – particularly one that does not have a geographical basis to it – and managing a single organisation or a small group of neighbouring hospitals. By requiring applicants to explain and codify their approach towards driving high quality across multiple organisations, some felt that credentialing could help prospective leaders of chains and franchises to develop their understanding of what would be required, and would challenge them to reflect on whether their organisations would have the right capabilities and capacity to succeed. We believe this could be a key potential benefit of credentialing, and recommend that if a credentialing process is developed, this should be seen as an explicit aim. By this, we do not mean that standardised packages of developmental support should be available to an organisation after passing through the credentialing process, but more that the aim should be to trigger and encourage internally-driven development.

An important distinction should be made between two alternative visions for credentialing. Credentialing could be conceived of as the preliminary stage in a formal procurement process – i.e. as a framework designed to simplify subsequent stages of major transactions between organisations. Alternatively, it could be seen as something which is more about recognising success – akin to a 'kitemark' – potentially with some relatively minor implications for subsequent transaction processes but without fundamentally changing these.

As we shall see in section three, this distinction has important implications for the scope of credentialing. **The focus of this report is primarily on the former model, in which credentialing is assumed to be part of a formal transaction process** – and we highlight some of the significant challenges that taking this approach towards credentialing would create. However, our core findings – particularly with regard to assessment criteria – will remain relevant to the 'kitemark' model.

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

## What kinds of organisational models?

In the previous section we described an important distinction regarding the purpose of credentialing. If credentialing is intended to be the preliminary stage of formal transaction process, this would have implications for the kinds of organisational models it could be appropriate for. We argue that this form of credentialing would only be appropriate where there is a change of management control. This could include the following:

- Service level chains
- Multi-service chains
- Management/operational franchises

The relevance of this model of credentialing to other organisational models is less obvious. Federations are by their nature a collective enterprise of willing partners, and as such it is hard to see how credentialing of individual organisations would be helpful in this context. Similar arguments apply to joint ventures. It would be a major inhibition to entrepreneurial activity if organisations required credentialing before entering into a joint venture. In our view the authorisation process required to become an foundation trust, alongside the checks and balances provided by competition rules and Monitor's oversight, would be more than adequate credentialing for these activities. In the case of vertically integrated care organisations, we would argue that it would be more appropriate for the regulatory oversight and challenge to be around the proposed new organisational structure rather than any individual organisation wishing to pursue this strategy.

If however credentialing is seen as a 'kitemark' which does not significantly alter legal transaction processes, it may be appropriate for other organisational models including federations, joint ventures and buddying relationships. Indeed, it may be more appropriate for these models since, as we argue in the following sections, it will be challenging to create a process which predicts with any degree of certainty that a provider will be able to manage a chain or franchise successfully – potentially undermining the value of a 'kitemark' for these purposes.

## Whole-organisation Vs service-level changes

As outlined above, this report focuses on the potential use of credentialing in situations where there would be a change in management control. An important question that follows from this is whether credentialing should be limited to situations where the change in management control applies to the whole organisation (multi-service chains/ franchises) or whether there would also be value in credentialing providers to enter into service-level arrangements. Some interviewees suggested that there may be more appetite for building service-level chains, at least initially, as the risk involved would be lower. The example of Moorfields Eye Hospital is often cited but should perhaps be treated with some caution, as the example relates to highly specialised services and it is not clear how generalizable this experience is to other clinical areas.

The approach we take in this report is to highlight where the necessary assessment criteria may be different depending on whether the focus is on organisation- or service-level changes.

## Other considerations

There are several other questions about the scale and scope of credentialing which would need consideration:

- Should credentialing be limited to organisations where there is a similar service scope, or should there be no restrictions on this? For example, could a mental health provider be credentialed for running an acute trust, or vice versa?
- Should there be any limits to the scale of transactions which providers are credentialed to undertake – particularly for providers with less relevant experience?
- Would a credentialing process be necessary for chains/franchises involving geographically contiguous organisations, or is the existing merger and acquisition regime sufficient for this? Should the focus be primarily on enabling non-geographical arrangements?

On the question of geography, the key requirement is that credentialing does not create an unnecessary barrier to mergers and acquisitions (or other relationships) between neighbouring organisations. It would be unduly restrictive to limit these kinds of transactions to organisations that are credentialed, as there may be situations in which merger between neighbouring organisations might be the best option even if the organisations involved have no appetite to enter into wider non-geographical management relationships and no interest in becoming credentialed to do so. However, in the case of mergers or acquisitions involving an organisation that has applied to become credentialed, assessments made as part of a credentialing process would be likely to have some bearing on Monitor's judgement of proposed mergers and acquisitions – Monitor may be less likely to give a trust permission to take over a neighbouring trust if the former has failed to become credentialed.

Our view on the questions regarding service scope and transaction scale is that in most cases these will be best addressed on a case-by-case basis rather than as part of the credentialing process. As we argue in the next section, however credentialing is devised there will be a continued need for robust assessment of each individual transaction, and it is at this stage that most decisions should be made regarding the limits of a credentialed organisation's capabilities. There may, however, be some merit in having a credentialing process which recognises that some providers may be ready to go further than others – some options regarding this are discussed in section 7.

A final consideration is the level of challenge in the target organisation. Much of the discussion regarding chains and franchises has been framed in the context of provider failure – the assumption being that the purpose is to encourage high-performing organisations to take responsibility for struggling trusts. However, there may be some appetite among high-performing organisations to build relationships with good trusts – which with their support can become excellent. This too may have implications for the transaction assessment process, which might need to be less demanding for a transaction involving two well-performing organisations relative to a situation where one organisation has serious performance problems. It would be regrettable if, by creating a credentialing process designed to serve the challenge of organisational failure, the process is made less suitable for supporting the development of chains/franchises where baseline performance is at a higher level.

## 4. How would credentialing relate to transaction-specific processes?

It is important to understand how a credentialing process could relate to existing processes for assessing the likelihood of success of significant organisational changes such as mergers and acquisitions. The current process used by Monitor is summarised in Box 1, below.

**Box 1 – What is the existing transaction process?**

The existing process used by Monitor for assessing significant transactions consists of three main stages, listed below. This is followed by review by the Competition and Markets Authority where it is considered there may be a reduction in consumer choice – particularly for transactions involving neighbouring organisations.

- Stage 1: Strategic options – Monitor assesses the strategic rationale and offers initial informal challenge of robustness
- Stage 2: Outline business case – 4-6 week process that looks at organisational management, capacity and approach
- Stage 3: Full business case – Detailed review of final business case, board-to-board meeting with Monitor, and issuing of transaction risk rating

For more details see: 'Supporting NHS providers: guidance on transactions for NHS foundation trusts'
https://www.gov.uk/government/publications/supporting-nhs-providers-considering-transactions-and-mergers

It is clear that credentialing could not replace transaction-specific assessment entirely – the nature of these large-scale organisational changes being too complex and too heterogeneous. The question that therefore needs to be answered is what could be assessed once, as part of a credentialing process, and what needs to be assessed on a case-by-case basis for each specific proposal, as part of transaction-specific assessments? We explore this question for specific assessment criteria in section 6.

In terms of the overall approach, a number of different balances between credentialing and transaction-specific assessment could be struck. At one extreme, credentialing could be a highly streamlined process based largely on existing data, followed by more substantial assessment at the transaction stage. At the other, credentialing could involve more in-depth quantitative and qualitative assessment of all dimensions described in section 6, with a much lighter process at the transaction stage (see figure 2).

***Figure 2 – Relative weight placed on credentialing versus transaction-specific assessment***

**>>> More in-depth assessment at credentialing stage >>>**

| | **'Light' credentialing** | **'Medium'** | **'Strong'** |
|---|---|---|---|
| **Credentialing** | PQQ questions<br>Good CQC rating | 'CQC plus' – with particular emphasis on leadership capability, depth & breadth, staff survey results | In depth assessment of all domains, drawing heavily on qualitative feedback |
| **Transaction** | Most of the assessment taking place on a transaction-by-transaction basis | Focusing on how generic competencies and models will be applied to this specific transaction | Much lighter assessment at transaction stage – validating & updating previous assessments |

The balance of opinion among contributors to our research was that credentialing should be kept light and based as far as possible on existing measures (e.g. CQC assessments, staff survey data). This was partly out of recognition that a robust transaction-specific assessment would still be necessary, regardless of the approach taken to credentialing. The complexity and heterogeneity of potential transactions means that much of the necessary assessment cannot be done in the abstract, but only in relation to a specific transaction. For example, the challenges facing a struggling trust can be highly specific to that organisation, and many of the competencies required of an organisation offering a new management framework would therefore need to be judged in relation to these specific challenges.

The argument developed in section 2 – that credentialing is conceived of as a mechanism for keeping out the most unqualified providers, rather than as a guarantee of quality – would also suggest that a streamlined approach to credentialing would be most appropriate. Under such a system, there could be initial expressions of interest from providers that might consider taking on additional management responsibilities, with some of these then being removed from the list if they failed to meet basic criteria. The onus would then be on transaction-specific assessment to ensure the selected provider(s) are capable of bringing about improvement, and that there is a clear benefits realisation strategy for the specific arrangements proposed.

A potential benefit of a 'light' form of credentialing is that it could act as a trigger for further organisational development, by clarifying areas where improvement may be needed before the organisation attempts a significant extension of its managerial responsibilities. In this way it could be analogous to the FT authorisation process (albeit with a distinct purpose), which created an impetus for change among organisations in the 'pipeline'. On this view, passing through the credentialing process could then mean that an organisation's readiness is improved by the time it embarks on any major organisational transactions.

The necessity of robust transaction-specific assessment raises a fundamental question of whether a credentialing process would succeed in reducing transactional burdens and make it easier to enter into new management arrangements. This risk is explored further in section 8.

## 5. Which types of organisation could be credentialed?

Much of the debate around credentialing has focused on the role of high-performing NHS organisations in supporting challenged providers – congruent with the terms of reference of the Dalton review. Within this, the focus has been predominantly on acute hospital trusts. However, other forms of organisations could also be applicable for credentialing, including:

- Other NHS providers e.g. community or mental health trusts
- For-profit private sector organisations
- Non-profit providers e.g. social enterprises

In designing a credentialing process it would be important to ensure that the assessment criteria do not unfairly disadvantage one sector over another – whether it be NHS organisations over the independent sector (or vice versa), or acute trusts over other providers. For example, an assessment of relevant prior experience would clearly be important (see section 6) but must not be conducted in a way that would debar NHS organisations with limited experience of merger and acquisition or managing chains from having the opportunity to gain this experience.

Creating a process which is open to all organisations with the necessary competencies would be important from two perspectives. First, a process which restricted access to providers from one sector without clear justification would likely be open to challenge under competition law (we would recommend the Dalton team seek legal advice on this issue if not already received). Second, there may be relevant expertise in a variety of sectors, including existing providers of private healthcare in the UK and abroad (many of which already operate as chains) and potentially also other organisations with relevant management expertise from other sectors.

A core challenge in designing a credentialing process would therefore be to devise assessment criteria which set the bar sufficiently high – particularly with regard to prior experience – but which also leave a pathway open for new entrants. Some potential new entrants would be able to demonstrate relevant experience of service provision relatively easily (for example major providers of health care services from other countries), whereas for others (e.g. most private providers currently operating in the UK) the scale and scope of their existing portfolio is very different from the kinds of services potentially covered by credentialing.

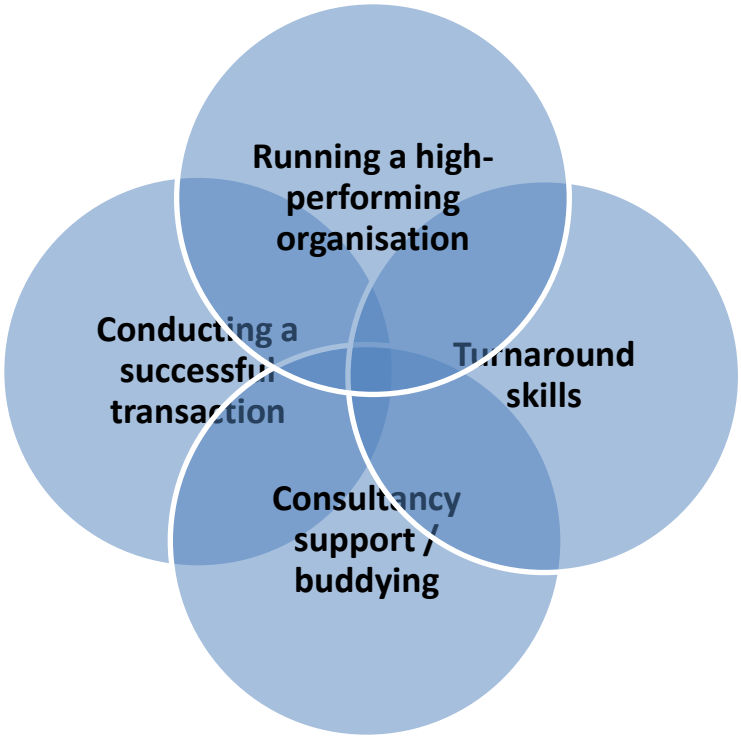
Some of the contributors to our research suggested that the credentialing process could be designed exclusively with new entrants in mind, on the grounds that established NHS providers are already subject to a number of assessments including the FT authorisation process and regular performance review by CQC and Monitor. There would however be political risks if the process were designed solely for independent sector organisations. We suggest the most constructive approach would be to create a credentialing process which builds on (and extends) the existing assessment frameworks applied to NHS organisations, and thereby avoids repetition for those organisations that have already been through the FT authorisation process, but which also leaves a possibility for new entrants to be assessed (see section 7).

## 6. Potential assessment criteria

As argued in section 2, the competencies required to run a chain or franchise successfully are varied and – importantly – are not identical to the skills needed to drive performance a single unitary organisation. They are also not the same as those required for running a small number of geographically contiguous hospitals (a more typical arrangement currently in the NHS).

Interviewees were clear that there are multiple overlapping skill sets which are relevant – including turnaround skills, or prior experience of transactions involving merger or acquisition (see figure 3 below). This has significant implications for credentialing, as it means that (1) it cannot be assumed that success will transfer readily from a high-performing organisation to a new acquisition, and (2) unless they are adapted for this new purpose, existing assessment frameworks designed to measure organisational performance may miss important competencies which are highly related to the likelihood of success.

***Figure 3 – Overlapping competency sets***




The most important assessment criteria identified by our research can be categorised in terms of the following dimensions:

- 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

This section describes what would need to be assessed within each of these dimensions. Across all areas, the critical part of the assessment would focus on understanding the degree of transferability to a new organisational context (for example, assessing the transferability of the approach towards leadership development or quality improvement). Taken together, 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.

Where relevant, we describe how the assessment criteria might vary depending on the scope of the transaction (e.g. comparing whole-organisation to service-level changes). We also attempt to distinguish between criteria that could be included in the initial credentialing process, versus those which would be more appropriately assessed in relation to specific transactions.

It should be noted that the applicability of these may vary 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. Section 7 analyses the degree of alignment between these assessment criteria and the existing frameworks used by Monitor and CQC.

Several of the assessment dimensions discussed here resonate with conceptual frameworks developed in other sectors. For example, the concept of the 'high-reliability organisation' is relevant and worth may be helpful in developing some of the assessment criteria, particularly in relation to leadership, culture and quality improvement (see appendix A).

## Leadership

Interviewees placed considerable emphasis on the need to understand the quality and style of leadership in an organisation. In particular, we would draw attention to two aspects of leadership:

- **Depth and breadth of leadership** – in order to be successful in running a chain or franchise, leadership skills will need to extend beyond the top team. There needs to be talented leaders (including clinical leaders) at all levels to ensure that performance can be maintained during and immediately after a transaction process, when the attention of the executive team may need to be diverted towards the new acquisition. Prior experience of franchising arrangements within the NHS (e.g. between Frimley Park and Ashworth St Peters, or Basildon and Dartford) highlights the difficulty of sustaining a 'heroic' leadership style in multiple organisations over time.

- **Physiology of leadership** – In addition to assessing the calibre of individual leaders, an important part of a credentialing process would be to examine *how* leadership skills are cultivated within an organisation. Leadership strategies can provide one form of evidence regarding the approach taken towards understanding and meeting leadership needs within the organisation. The ability to articulate this approach will be important in the context of taking on management responsibilities for another organisation, which will often involve transporting this approach to the new organisation. In the case of service-level

arrangements, the credentialing process would need to explore the organisation's approach to nurturing clinical leadership within the relevant service-line.

Both of these would be an important part of a credentialing process. Transactional assessment could then focus on any aspects of leadership of particular relevance to the specific transaction, for example leadership within the service-lines where the most significant changes are envisaged. Depending on the scale of the transaction under consideration, it may also be necessary to return to the question of the depth and breadth of leadership at the transaction stage, as the assessment of this may need to be more challenging for particularly large transactions.

The emphasis placed on the depth and breadth of leadership mirrors the findings from The King's Fund's previous work on leadership in the NHS, which has stressed the need for leadership to be collective and distributed, with skilled clinical leaders working alongside experienced managers (Ham 2014; West et al. 2014).

Research on mergers and acquisitions suggests that transactions involving significant organisational change are more likely to be successful with "socialised charismatic" leadership that involves people in building a shared vision, rather than "personalised charismatic" leadership in which the leaders own vision is projected (Waldman & Javidan 2009). Leaders need to be competent and trained in the process of transforming organisations and understand follower motives when leading organisational change. Particular attention is needed to communication, compassion and a transparent change process (Kavanagh & Ashkanasy 2006).

## Organisational culture

Alongside leadership, organisational culture was the area emphasised most strongly by interviewees. The existence of a strong and positive culture, with patterns of behaviour that emphasise safety, improvement, transparency and openness, is an important dimension of quality for any organisation working in health or social care. Of particular relevance to credentialing is a **demonstrable means of changing culture** – the capacity to shape the culture of an organisation or service over time. Organisations will need to be able to articulate how they would build a positive culture in an acquired organisation or service, and their approach towards creating a shared sense of purpose across multiple sites.

While assessments at the credentialing stage could focus on the kind of culture present in the core organisation and the methodology for bringing about cultural change, at the transaction stage it would be important to assess the '**cultural fit**' between the two organisations – to ensure that the culture of the recipient organisation is amenable to the alternative ways of working that a credentialed organisation would bring with it. Evidence from previous mergers and acquisitions highlights this as a crucial determinant of success (KPMG 2011; Kanter 2009; McKinsey & Co. 2010).

Research has consistently found that addressing cultural issues is critical to achieving a successful outcome from mergers and acquisitions, but also highlights how difficult this can be to do in practice (Harding & Rouse 2007; DiGeorgio 2003; McKinsey & Co. 2010). The organisation that would be leading a prospective chain or franchise would need to demonstrate a good understanding of the cultural challenges existing in the other organisation, and how they would tackle these.

Cultural audit tools have been developed and are widely used in some sectors. However, challenges remain in terms of assessing organisational culture in a reliable and robust way. There are many different ways of assessing culture (Delobbe et al. 2002), and within healthcare organisations

multiple cultures can co-exist, with significant variations between clinical departments in hospitals (Sexton et al. 2006) and between staff groups (Wakefield et al. 2010).

The existence of significant cultural variations between different parts of the same organisation does present a challenge to credentialing, particularly when the goal is to support whole-organisation chains or franchises. The assessment process could examine any evidence of variation within an organisation applying to become credentialed, as it gives an indication of the leadership's ability to spread a positive culture across an organisation, and by extension, into other organisations.

## People management and staff engagement

Closely related to leadership and culture is the approach taken towards people management and staff engagement. There is evidence that measures of staff satisfaction, and in particular staff engagement, correlate closely with patient outcomes (West et al. 2011).

Interviewees consistently argued that high levels of staff engagement – as measured by staff survey results, for example – would need to be a core component of any credentialing process. Key workforce metrics such as employee turnover, vacancy and sickness levels should also form part of the assessment. There should be evidence of active support for effective team work within and across organisations.

As with leadership, it would be important to assess both the current levels of engagement and the *approach* taken towards engaging staff. Leaders should be able to articulate an explicit model for engaging staff that could be applied elsewhere.

The assessment could also ask for specific evidence relating to experience of engaging staff during periods of significant organisational change. In addition to this it would be relevant to assess core HR skills, as key components of success during and after a transaction would be identifying which staff in the acquired organisation should stay or be replaced, and recruiting new talent as necessary.

At the transaction stage, the focus of assessments would shift from understanding the level of staff engagement in the core organisation to analysing how the organisation's engagement methodology would be deployed in the new organisation, and the specific challenges that might be anticipated in doing this. An important part of this would involve communicating to staff a compelling story about the new organisational arrangements and how they will lead to improvement, in order to overcome potential resistance to change (Christensen et al. 2011; Gaynor et al. 2012; Dash et al. 2012).

## Improvement capacity and methodology

Running a chain or franchise requires the capability to drive quality improvement through use of consistent processes and protocols. A key message from our interviews was that leaders of high-performing NHS organisations – including those who have overseen significant improvements – do not necessarily operate with an explicit methodology describing how these changes can be brought about. While leadership by instinct may succeed within single organisations, to transport success to a new organisation leaders will need a codified methodology for quality improvement. A credentialing process would need to ask for a clear articulation of this methodology, and where possible evidence of it being put into practice successfully.

A caveat here is that although there is increasing evidence about the effectiveness of quality improvement methodologies in the health care sector, for example in surgical settings (Nicolay et al

2012), it is not clear which methodologies work best in which circumstances, and what the most important factors determining successful diffusion of innovation might be (De Silva 2014). The assessment of improvement capacity would therefore need to be flexible to a range of approaches, with some interviewees suggesting that organisations applying for credentialing should not be overly dogmatic in their commitment to any specific methodology.

Research on mergers and acquisitions highlights that a codified improvement methodology is necessary but not sufficient for success. What is also needed is improvement capacity and capabilities which fit the problems being addressed – which could relate to finance, culture, quality, safety, or a mixture of all of these (Camara & Renjen 2004; Ashkenas et al. 2011; KPMG 2011). It would therefore be necessary to assess whether the proposed approach towards improvement would be suitable for a specific organisation. This would need to be done as part of transaction-specific assessments.

## Innovation

Related to the above, interviewees argued that the ability to create a climate which promotes innovation and permits experimentation will be critical to running a successful chain or franchise. This will be important given the need for radical service change in many of the most challenged trusts. Organisations should be able to demonstrate a track record of fostering innovation and investing in new ideas, for example information technologies. Without this there is a risk that new management arrangements could simply deliver 'more of the same', albeit within a new institutional framework.

## Governance

Strong governance arrangements within the existing organisation are an obvious pre-requisite to being credentialed. As a minimum, assessments at the credentialing stage would need to demonstrate that there should be clear roles and responsibilities for the board, executive team and governors, a low Monitor risk rating and a good governance score. For new entrants where this existing information does not exist, credentialing would need to involve an assessment of the quality of governance equivalent to those already undertaken for NHS organisations.

Beyond this, any organisation undergoing the transition from operating a single hospital or group of neighbouring hospitals to running a geographically dispersed chain or franchise should be able to demonstrate an awareness of the implications of this in terms of the change in the management task. A focus on operational issues will need to be replaced with a higher-level focus on governance and quality assurance processes.

At the transaction stage, there would need to be an in-depth assessment of proposals regarding group governance structure and lines of accountability within any potential chain/franchise, and the proposed approach to the devolution of budgetary control and assurance processes. While most of the detail would need to be assessed on a case-by-case basis, the credentialing stage could ask for evidence that these issues have been given some consideration.

If an organisation was interested primarily in service-level rather than whole-organisation arrangements, the assessment of governance processes would need to be adapted to this purpose. For example, the credentialing process would need to focus on how governance processes within the chain would intersect with the wider governance framework of the organisations where franchised services would be delivered.

## Quality and financial performance

As with governance, both the current performance and the proposed approach towards performance in the context of new management arrangements would be relevant, with credentialing focusing on the former and transactional assessment exploring the latter in greater detail. The credentialing process would need to consider all available performance metrics including:

- quality, safety and effectiveness (including CQC assessment of quality of care)
- patient satisfaction
- financial performance

Our interviews raised the question of what the most relevant form of success against these metrics would be. Alternatives include:

- Excellent current performance
- Sustained high performance over multiple years
- A trajectory of improving performance

This question follows from the observation that competence at running a high-performing organisation does not necessarily translate into success at turning around a poor-performing organisation or service and driving improvement. There is also a concern that there is a potential to 'misattribute' the causes of success – which could relate to path dependency and subtle environmental local rather than something replicable which can be transferred to another organisation.

For organisations applying to become credentialed specifically with regard to service-level arrangements, the performance of the whole organisation would still need to be assessed as part of the credentialing process, as their ability to manage a service-level chain or franchise would clearly be dependent on wider organisational performance.

Current performance is one area where it could be difficult for new entrants to meet the necessary assessment criteria. Healthcare providers not currently working for NHS patients are not subject to CQC inspections, and their financial history may be commercially sensitive. This challenge would be even greater for potential new entrants from other sectors, with no prior experience of healthcare provision. Some flexibility may be possible – for example by looking at evidence of high performance in delivering other public services – but it may be more feasible to do this in relation to a specific transaction rather than at the credentialing stage (see section 4).

At the transaction stage, an organisation would need to be able to outline a convincing strategy for ensuring continued excellence in the core business during and after the transaction, and their approach towards delivering quality in the new organisation or service.

## Partnership working and system leadership

An important point stressed by participants throughout our research was that poor performance in challenged hospitals is rarely a consequence of internal organisational factors alone. If chain and franchise arrangements are to help in addressing wider systemic problems, the organisations

running them will need to be highly adept at working in partnership with other local organisations, facilitating reconfiguration and acting as a system leader. In the current financial environment, collective leadership in local health systems has never been more important or necessary (West et al 2014).

Part of a credentialing process may therefore need to involve an assessment of the degree to which an organisation can work effectively in partnership – exploring their track record of working well with local partners, and asking how they would ensure buy-in from local partners while working remotely. Experience and understanding of large-scale service reconfiguration would also be a highly desirable attribute, given the need for this in many of the areas where performance problems are most acute. This may be less applicable to service-level arrangements, where the most important partnership would be with the local organisation in which franchised services were embedded, rather than with other partners in the surrounding health economy.

Assessment at the transaction stage would need to explore the particular system problems affecting the new acquisition, and what proposals the core organisation has towards working with local partners to address these challenges.

## Track record in mergers and acquisitions or turnaround

The clearest message from the evidence base on mergers and acquisitions is that the complexity of these transactions – and the high rate of failure – should not be underestimated. Research suggests that globally, an estimated 70% of all mergers and acquisitions in health care fail to achieve their objectives (KPMG 2011). In line with this, interviewees stressed the importance of acquiring sufficient prior experience before taking on any significant transaction. A credentialing process would need to see evidence of a clear model and approach towards acquisition – for example, in terms of whether there will be rapid movement to uniform structures and processes across sites or a willingness to accommodate some differences.

An important attribute of successful chains or franchises in the private sector is the ability to undertake a robust evaluation of potential acquisitions, for example to understand their potential for change and improvement. Organisations would need to demonstrate at the transaction stage that they have performed an evaluation along these lines. Critically, there must be the confidence and the freedom to walk away from a deal if there are indications that the potential acquisition does not fit the organisation's operating model.

The importance of direct experience creates a significant challenge for credentialing NHS organisations, which in the main would not have a track record of merger and acquisition against which they could be judged (with some exceptions). In place of this experience, the assessment process could look for a number of proxies:

- Recent experience of driving improvement in their own organisation
- Recent experience of supporting improvement in another organisation
- Proven ability to manage significant change
- Experience of merger and acquisition among non-executive directors

It should be noted that even where there is prior acquisition experience, this does not by itself guarantee success. There is evidence from the commercial sector that prior experience does not necessarily result in better outcomes – success is dependent on the nature, performance and timing of the previous experience (Hayward 2002).

## Organisational capabilities (support functions)

Finally – but importantly – the back-office functions in an organisation also need to be capable of supporting any extension in management responsibilities. It would be necessary to include an assessment of whether an organisation's finance function has the capacity to cope with a large-scale transaction, and whether there is a sufficiently strong IT system and facilities management. Clearly the capacity needed would vary significantly according to each specific transaction, and would be likely to be less for service-level arrangements. Much of this assessment would therefore need to be done at the transaction stage. However, it may be helpful at the credentialing stage to test that an organisation has a reasonable understanding of how it would go about assessing how a transaction might test their support functions, and of how they would then build the necessary capabilities and capacity in response to this analysis.

# 7. How a credentialing process might be conducted in practice

## Building on existing assessment frameworks

A strong message from our interviews and expert seminar was that any credentialing process should avoid duplication and should, as far as possible, build on and align with existing assessment frameworks used in the NHS.

There are clear points of alignment between the assessment dimensions described in the previous section and the assessment frameworks used by Monitor, CQC and the TDA. Alongside their assessments of quality of care and financial performance, all three organisations assess leadership, governance and culture as part of existing processes. For example, the five key lines of enquiry in the well-led domain of the new CQC assessment framework are:

1. Vision, values & strategy
2. Governance arrangements
3. Leadership and culture
4. Patient and staff engagement
5. Continuous learning

These are in turn aligned to the 10 key questions used in the TDA/Monitor well-led framework.

Most of the assessment dimensions described in section 6 can be aligned against these five key lines of enquiry. However, in each of the five areas, the questions currently examined by CQC/Monitor would need to be extended and adapted for the new purpose of evaluating an organisation's suitability for running a chain or franchise. Often the critical adaptation would be that in addition to looking at the current level of performance, the credentialing process would need to look for a codified model underpinning success, for example an explicit improvement methodology, or a replicable approach towards leadership development or staff engagement.

Table 1 illustrates in greater detail how the relevant areas described in section 6 align with the well-led assessment frameworks used by CQC and Monitor. This analysis suggests that a positive assessment from CQC and TDA/Monitor, based on existing frameworks, would be necessary but not sufficient for the purposes of credentialing – particularly while the new CQC methodology is at a developmental stage. It could therefore be a helpful 'pre-screen' but should not form the sole basis of the assessment.

The possibility of developing a credentialing process which builds upon existing CQC/Monitor assessments, rather than repeating them, again raises the question about how non-NHS providers could be credentialed. If the intention is to allow providers from outside the NHS to apply to become credentialed, these will not previously have been through the same assurance processes as a foundation trust. However, it may be possible to design a credentialing process in which foundation trusts supplement the information already provided to Monitor/CQC with information relating specifically to running chains or franchises – plugging the gaps in the existing information – whereas non-NHS providers would be required to go through a fuller process analogous in some respects to parts of the FT authorisation process, in addition to providing the more specific pieces of information.

***Table 1 – Potential credentialing assessment criteria mapped against the CQC and Monitor well-led frameworks***

| Key line of enquiry | Covered by CQC/Monitor assessments | Areas where more evidence may be required |
|---|---|---|
| Vision, values & strategy | • Clear vision, and a credible strategy for achieving this<br>• Staff in all areas understand the organisation's vision and values | • Strategy for acquired organisations<br>• Strategy for ensuring continued excellence in core business |
| Governance arrangements | • Clear roles & responsibilities for board, exec team, governors<br>• Active collaboration and engagement in decision-making<br>• Arrangements that support openness & constructive challenge | • Awareness of the shift in approach towards governance required for successful management of a chain or franchise<br>• Proposed group governance structure & lines of accountability<br>• Proposed approach to the devolution of budgetary and other control and assurance processes |
| Leadership and culture | • Leadership strategy setting out current and future needs<br>• Appropriate leadership skills on the board, exec team and elsewhere<br>• Leadership behaviours that encourage openness & transparency<br>• Culture of collective responsibility<br>• Culture which emphasises the importance of safety & quality | • Breadth and depth – leadership capacity beyond the senior team<br>• A focus on 'how not who' – the approach taken to building leadership skills and creating a positive culture<br>• Ability to articulate how they would build positive culture in acquired organisation, and capacity to do so<br>• Evidence of success in changing culture over time |
| Patient and staff engagement | • Proactively engaging with patients and families<br>• High levels of patient satisfaction<br>• Patient experience data reviewed alongside other performance data<br>• Consistently high levels of staff engagement & satisfaction | • Codified model for engaging staff and patients that can be applied elsewhere<br>• Approach to engaging staff during periods of significant organisational change |
| Continuous learning | • Time and resources invested in quality improvement<br>• Demonstrable performance improvement<br>• Support for safe innovation & evaluation of service changes<br>• A systematic approach to working with others in the health and social care economy to improve outcomes and quality<br>• Devolution of responsibility to service level | • Capacity to codify approach to improvement – and evidence of this being put into practice successfully<br>• Track record in managing significant change |
| **Areas not covered in depth as part of CQC / Monitor well-led frameworks** | | |
| • Track record in mergers and acquisitions<br>• Experience of turnaround / driving improvement in another organisation<br>• Organisational capabilities required for supporting acquisition | | |

It should be noted that the distinction between NHS and non-NHS organisations is not the only one that will have a bearing on assessment processes. Within the NHS, there are also differences in terms of the data available for acute trusts and community trusts. In the case of the latter, our ability to assess the strength of current performance is significantly weaker. This deficiency would also need to be addressed if the credentialing process is to be based on a level playing field.

## Who would lead the credentialing process?

Related to the question of alignment is the question of which organisation – or combination of organisations – would lead the credentialing process. The close alignment with the assessments performed by CQC and Monitor suggests a potential role for both of those organisations. Our view, and the predominant view among those involved in our research, is that Monitor would be best-placed to lead the assessment, and has the most relevant expertise. Given that Monitor already leads the assessment process at the transaction stage, there would be a risk of duplication and inefficiency if a different organisation led the credentialing process. However, CQC would also clearly have a role to play, and credentialing decisions would need to draw on the information gathered as part of CQC inspection processes.

There would potentially also be a role for Monitor in the matching of challenged trusts to credentialed providers (see 'Matching providers', below).

## The approach to measurement

There would be clear advantages to basing a credentialing process as far as possible on existing assessments and data – in order to minimise the burden on the assessed and the assessors. However, contributors argued that many of the most important dimensions would require assessors to gain a detailed qualitative understanding of an organisation – for example with respect to leadership and culture. It is likely that credentialing would need to combine objective criteria with subjective assessment based on interviews with key personnel. Several contributors cautioned against conceiving of it as a tick box exercise with a rigid scoring system, although a less rigid approach would potentially be more open to challenge.

The emphasis placed on assessing the depth and breadth of leadership skills suggests that staff beyond the executive team may need to be interviewed as part of a credentialing process. A decision would need to be taken regarding how deep and how broad these evidence-gathering processes should go. Assessors may need to meet clinical and other leaders face-to-face to get a sufficiently robust understanding of the nature of leadership within the organisation. The value of hearing from those beyond the top team would need to be weighed against the additional burden imposed.

## Possible outcomes of the assessment

Credentialing could be a binary process (a provider is either credentialed or not) or could involve a number of gradations. Some interviewees suggested that there could be merits in having different levels based on the extent of previous experience, or on the scale of the transaction. For example, a provider with prior experience of acquiring other organisations might be credentialed to take part in transactions of any size, whereas a provider with less direct experience might at first only be credentialed to take part in transactions up to a set percentage of the organisation's current

turnover. Such an approach could widen the pool of organisations involved, but at the expense of creating a more complicated system and process.

Another possibility would be to devise a process that distinguishes between specific skills, so that rather than being credentialed for any form of extended management responsibility, a provider might be credentialed with respect to turnaround, or asset management (for example). A competency matrix could allow the type of challenges being faced by a trust to be 'matched' against the specific skills that credentialed providers bring. This was the kind of approach used in the 2007 framework for procuring external support for commissions ('FESC' – see section 8), in which some suppliers were approved to provide a specified set of services, while others were recognised as fully comprehensive providers. Credentialing for specific skillsets could help to overcome some of the concerns regarding the heterogeneity of the transactions that credentialing could potentially cover. However, our main concern would be that it implies a degree of scientific reliability and precision that is not supported by the evidence. There is also a risk of making the process overly complex. Finally, if this approach was to be considered, there would need to be an indication that the market of providers potentially interested in and capable of becoming credentialed is large enough to be sub-divided by competency group.

## Renewing and revoking credentials

An important issue identified during our interviews was the question of what time period credentialing would last for, and how the status of a provider would be renewed or revoked.

The consensus of those involved in our research was that once a provider is credentialed, 3-5 years would be a reasonable length of time for the status to apply for. However, there were also suggestions that there may need to be periodic 'check-ups' during this time, to ensure the basis of the assessment remains valid. These could be particularly useful given limited confidence about the predictive power of the initial assessment process. Check-ups would need to be kept as light as possible, and could take place:

- at set intervals e.g. annually,
- after a pre-determined number of transactions,
- in advance of a particularly large transaction, above an agreed threshold; or
- when there are specific grounds for concern.

There would need to be a robust process around when and how 'de-credentialing' might take place. Potential triggers for revoking a provider's credentials could include critical CQC inspections, negative assessments from Monitor, or serious safety breaches. There would also need to be a process for managing the implications of this for challenged trusts belonging to a chain or franchise led by an organisation that loses its accredited status – there is a risk of their performance being further destabilised by the process.

## Matching providers – voluntarism versus external challenge

Part of the process that will also require consideration is the mechanism through which credentialed providers are matched with challenged trusts. Importantly, would this process be led by the challenged trust, the credentialed providers or Monitor?

Interviewees consistently stressed the importance of voluntarism. There is little evidence that forced partnerships between organisations tend to lead to successful outcomes. The cultural and human aspects of organisational change can create significant barriers even when both partners are willing, and can be insurmountable if either or both organisations are coerced into new arrangements (KPMG 2011). This is highly pertinent to a situation where chains and franchises are seen as a potential solution to the problem of provider failure.

However, there are also reasons why an entirely self-directed process might not deliver the best results. First, it is not always clear that the challenged trust would have a sufficiently clear diagnosis of the problems that require solving, and therefore of what sort of organisation might be best-placed to offer a solution. Second, there are some potential conflicts of interest that could arise. Interviewees from the education sector described important lessons on this from the experience of Academy chains in the schools system. A common means through which 'sponsor' schools have brought about improvements in struggling schools is by replacing under-performing staff once the school becomes part of the chain. Where schools have been involved in selecting their own sponsor, there have been concerns about a possible conflict of interest, and a tendency to choose the least threatening option. The standard now is for the process to be driven by the potential sponsor school with facilitation from the local office of the Department for Education and Skills (DfES). In the NHS there would need to be a competitive process and the role of the Department of Health would not be the same as that performed by DfES in education (as DfES has more direct control over schools).

The scope of our work does not extend to answering the question of how credentialed healthcare providers should be paired with challenged hospitals, or whether this should be an entirely voluntary arrangement, but it does highlight that this part of the process will need significant further thought if credentialing is introduced.

## 8. Risks

In the previous sections we have described our findings regarding the design and implementation of credentialing, if a decision is taken to pursue the idea further. Our research did, however, also identify a number of risks which require serious consideration before the decision to proceed is made. Some of the risks can be illustrated by reference to the FESC framework (see box 2, below).

We identified the following as being the most significant risks associated with credentialing. These will be particularly pertinent if credentialing is seen as a preliminary stage of formal procurement processes (see section 2).

- **Detracting from the robustness of transaction-specific assessment** – The complexity and diversity of potential transactions means that robust transaction-specific assessment will always be needed (see section 4). An attempt to radically simplify the process at the transaction stage risks facilitating ineffective solutions which fail to improve the financial situation or quality of care in struggling trusts.

- **Failing to reduce bureaucratic burdens** – Given the continued need for robust transaction-specific assessment, there is a clear risk that credentialing will not reduce the total amount of time or resources required to undertake a transaction of this kind. At worst, it could increase the burden by adding a new stage to the process.

- **Misreading market appetite** – We have recommended that if credentialing is conceived of as part of the formal transaction process, it is relevant only for transactions where there is to be a change in management control – specifically for chains or franchises (see section 3). NHS providers contributing to our research suggested that the appetite for becoming involved in these forms of organisational models would be limited unless wider incentives and disincentives are addressed (see below).

- **Creating a redundant process** – Following on from the above, if credentialing fails to reduce bureaucratic burdens, or if providers are interested primarily in building different types of relationships not covered by credentialing, there is a risk that providers choose to circumvent the credentialing framework and conduct transactions through existing processes – as happened with the FESC framework (see box 2, below).

- **Inhibiting innovation** – There is a risk that by creating an incentive to enter into relationships with a limited set of providers, local innovation involving non-credentialed organisations could be inhibited. Novel solutions evolving out of local circumstances could be abandoned in favour of arrangements which are easier to enter into, but which may not be more likely to succeed.

- **Credentialing the 'wrong' providers** – The assessment process itself would be challenging to get right, and in particular the predictive power of the criteria described in section 6 is unknown. For example, it may be highly difficult to distinguish between providers who understand with sufficient clarity what the replicable ingredients of their success have been, and those who do not.

- **Losing clarity of purpose** – In section 2 we described a number of overlapping but distinct problems that credentialing could potentially offer a solution to – with different stakeholders putting the emphasis on different objectives. There is a risk of confusion and divergent expectations if the purpose of credentialing is not clear.

**Box 2 – Lessons from FESC**

The framework for procuring external support for commissioners (FESC) was introduced by the Department of Health in 2007 to make it easier for primary care trusts (PCTs) to enter into new relationships with external organisations offering support for various aspects of commissioning. 13 pre-approved organisations were included on the framework.

By the time of the framework's withdrawal, it had been used for a far smaller number of transactions than originally envisaged. Collectively, PCTs had conducted several hundred transactions for commissioning support, including with providers listed on the FESC framework, but in the vast majority of cases these were conducted outside of the framework, through existing procurement channels.

Research by The King's Fund published in 2010 suggests that several factors lay behind PCTs' decisions not to use FESC (Naylor and Goodwin 2010).

- Lack of clarity of purpose – FESC was originally conceived of as a vehicle for large-scale transactions, particularly those involving outsourcing. However, its remit widened during its creation, and ultimately the framework included a highly diverse set of organisations with very different offers to commissioners. This created confusion among PCT leaders regarding how and when to use the framework.

- Misreading the market – although many PCTs were interested in working with external organisations, in the main they wanted to do this through short-term consultancy projects or joint-delivery models. By contrast, the appetite for outsourcing parts of the commissioning function was significantly less than anticipated.

- Failing to reduce transactional burdens – FESC was perceived by many PCT leaders as being highly cumbersome. In particular, for the kinds of transactions PCTs were most interested in it was seen as it making the procurement process more burdensome rather than less.

The history of FESC provides an illustration of several of the risks associated with credentialing, as described above. The failure to anticipate these risks led to FESC becoming a redundant process and meant that the time and resources invested in its creation were not matched by the benefits achieved.

## Wider challenges for chains and franchises

Our research also identified wider challenges relating to the use of chains or franchise arrangements in the NHS, which could exist regardless of whether or not a credentialing process is used.

A strong view, from the stakeholders we engaged with, was that if the aim of the credentialing process is to facilitate engagement between high performing and poorly performing organisations, the transactional barriers that credentialing is designed to remove are not the primary obstacles to engagement. Consideration will need to be given to what other disincentives exist and how they may be overcome, as well as the incentives and how they might be maximised. This was thought to be particularly pertinent for situations where there is not close geographically proximity or where

the transaction does not create obvious strategic synergies. Without fundamentally changing these incentives and disincentives, there is a significant risk that there will be limited interest in leading chains and franchises among high-performing organisations.

We also heard challenges about the merits of using organisational solutions to what may be more deep-seated health economy-wide problems. For example, in many cases it is clear that poor performance is the consequence of the need for hospital reconfiguration and transformation across a geographical area, as much as being rooted in inadequacies in any one organisation. Similarly, some of the problems in challenged providers can be seen as symptoms of NHS-wide shortcomings such as the limited supply of strong clinical and managerial leadership and improvement capacity.

A final concern related to the scale of the challenge. At least 30 trusts are currently facing significant financial challenges which raise questions about the sustainability of their current organisational form. A further 35 or more are at risk of facing significant financial challenges by the end of 2014/15, according to data collected as part of the The King's Fund's 'Quarterly Monitoring Report' (Appleby et al 2014), and forecasts suggest there will be a cumulative deficit in 20 of the 25 NHS England area team geographies (Illman 2014). On the other side of the equation, there are currently 79 trusts assessed as having the lowest financial and governance risk rating by Monitor, and of these 79, only a minority are likely to be in a position to help struggling trusts. Our interviewees suggested that the most successful organisation would be unlikely to consider taking part in more than one major transaction every two or three years. On this basis, even under an optimistic scenario the growth of chains and franchising models may not provide a rapid or comprehensive solution to the problem of challenged trusts.

## Summary

The concerns highlight in this section challenge several of the key assumptions on which the idea of credentialing is predicated, and we recommend that thought is given to these before proceeding. The most fundamental challenges are summarised in table 2, below.

***Table 2 – Assumptions underpinning credentialing and challenges to these assumptions***

| Assumption | Challenge |
|---|---|
| Running chains or franchises would be more attractive to high-performing providers if transactional barriers were removed | It is not clear that transactional barriers are among the most important disincentives – a broader understanding of the key (dis)incentives is needed |
| It is possible to identify with sufficient accuracy those organisations which will be capable of running chains or franchises effectively | The predictive power of the assessment criteria identified in section 6 is not clear |
| The competencies needed for running chains or franchises are sufficiently generic across different transactions | There is evidence that the competencies needed are highly specific to each transaction |
| The transaction process can be made quicker and simpler without losing robustness | These are highly complex transactions and much of the time taken is spent on necessary activities e.g. building local relationships |
| The causes of poor performance can be located to an individual organisation, and how it is managed, rather than systemic challenges across the local health economy | In many cases the most pressing question may be to ask how to speed up redesign across whole systems rather than transactions concerning individual hospital trusts |

# 9. Conclusions and recommendations

If the idea of credentialing is pursued further, our work suggests that regard should be given to the following recommendations:

- Build as far as possible on the existing assessment processes used by CQC, Monitor and the TDA, but do not rely on these assessments alone. For credentialing NHS organisations – particularly foundation trusts – the credentialing process could extend and adapt the 'well-led' frameworks currently in use and focus on gathering supplementary evidence to fill in the gaps.
- Focus on the assessment criteria that matter most for achieving the desired outcome – in particular the capability to build a positive culture; promote innovation and improvement; and nurture leadership throughout the organisation. The emphasis in each of these areas should be on assessing the degree of transferability – which will require a codified approach towards leadership development, culture change and quality improvement.
- Create a process that is developmental in its own right. Passing through the credentialing process should help organisations to clarify areas for development if they intend to take on extended management responsibilities, and should also help them to function more effectively in their existing organisational form. There does not necessarily need to be developmental support packages provided as part of the process, but the aim should be to trigger and encourage internally-driven development.
- Design the process in a way that creates a pathway for new entrants from outside the NHS, and which allows these providers to demonstrate the capabilities already tested in the FT authorisation process and other assessments, along with the additional requirements specific to credentialing.
- Consider how credentialing decisions should be reviewed over time, and how credentialed providers can be validated periodically – particularly initially while the process is unproven.
- Ensure that a shared vision exists regarding the purpose of credentialing, and that all stakeholders understand this.

If credentialing is intended to be the preliminary stage of a formal transaction process, the following recommendations will also be important:

- Avoid undermining the rigor of transaction specific assessments by attempting to shift a significant part of the assessment process into the credentialing stage. Robust transaction-specific assessment will be necessary regardless of the design of the credentialing process.
- Apply the credentialing process only to transactions where there is a proposed change of management control.
- Conceive of credentialing as a process for ruling out inappropriate applicants, rather than acting as a guarantor of quality.

Regardless of whether or not a credentialing process is developed, a critical step in encouraging the development of new organisational models in the NHS will be to assess the other factors that may encourage or discourage providers from taking on additional management responsibilities. We are aware that work is being conducted on this as part of the wider Dalton review process. Our assessment is that taking action to strengthen the incentives and remove disincentives is likely to achieve more than credentialing alone. Importantly, it is not at all clear that transactional barriers are among the most important disincentives that need to be removed.

As the previous sections have discussed, there are a number of fundamental challenges to the assumptions on which the idea of credentialing is predicated. Taken together, these concerns raise

the significant possibility that a credentialing process would do little to catalyse the kinds of innovative management arrangements that it is hoped will help to spread high performance across the NHS. Given the significant investment of resources that would be needed to implement a credentialing process, and for providers to pass through it, the question must be whether the potential gains are large or likely enough to justify the costs. Previous attempts to create pre-approval frameworks in the health sector have not always delivered the intended benefits. The experience of the FESC framework in particular has a number of important resonances with the current proposals, and serves as a timely reminder of how credentialing could potentially fall short of its objectives – particularly if it is conceived of as a part of the formal transaction process.

Some of the concerns raised are less relevant if credentialing is intended as a marker of success which will not have significant implications for the subsequent transaction process through which new organisational models are brought about. However, the question of how effective it will prove to be as a catalyst for the growth of these new models remains a pertinent one.

# Appendix A-High Reliability Organisations

There is an overlap between the key assessment criteria identified by our interviewees and the features of leadership, culture and process improvement found in "High Reliability Organisations" as applied to health care.

The most commonly used definition of a 'High Reliability Organisation' (HRO) is a "consistently reliable organisation that operate in a complex environment where accidents might be expected to occur frequently, but which manages to avoid or seeks to minimise catastrophes" (The Health Foundation 2011) p6.

The concept of an HRO originated outside healthcare but there is now considerable enthusiasm for the application of its principles to healthcare (Chassin 2013) (Berg 2013) (Chassin & Loeb 2013). There are also examples of clinical areas such as critical care that have successfully applied the principles of high reliability to improve outcomes and develop a patient safety culture (Pronovost et al. 2006). In the United States, the Joint Commission, an independent body that accredits more than 18,000 health care organisations and leads initiatives to improve the quality of care, is spearheading work to help all healthcare organisations become high reliability organisations.

However, even the supporters of the concept acknowledge that framework's such as the one above have not been empirically tested and that more research is needed to determine their validity (Chassin & Loeb 2013). Others make more fundamental challenges. Vincent et al (Vincent et al. 2010) highlight that while studies point out a wide range of characteristics said to be important for reliable performance, it is not clear which are the most important, and different researchers have reached different conclusions.

The complexity of health care can also make it difficult to develop well-integrated and cohesive cultures of reliability. "Hospitals often encompass a myriad of subcultures that mirror the structural complexity of the hospital system and its occupational differentiation. Furthermore, some professional beliefs and norms clash with HRO norms". (Tamuz & Harrison 2006)p1658.

This suggests that it would be hard to make a judgement during a credentialing process as to whether an organisation is a "High Reliability Organisation" but some of the key features of an HRO could usefully be explored within the dimensions of leadership, culture and process improvement.

Overall, we would argue that it would be more beneficial to align the credentialing process with the assessment frameworks already used by CQC and Monitor, rather than with a new theoretical framework based on the HRO concept. However, the literature on HROs may help in developing some of the assessment criteria within the dimensions mentioned above.

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