Department of Health

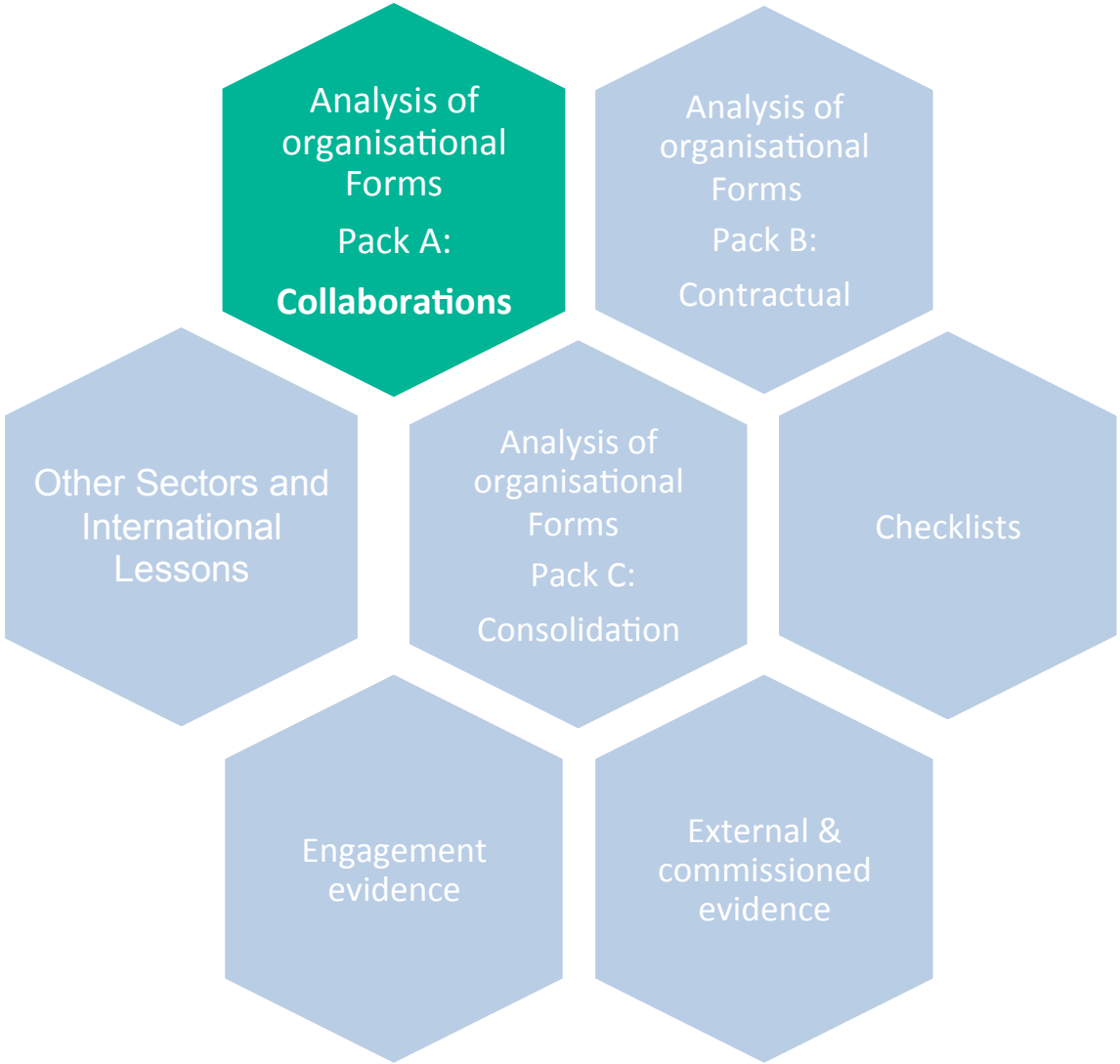
Dalton Review: Examining new options and opportunities for providers of NHS care

Pack A: Collaborative Forms

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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Pack A: Collaborative Forms

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Enabling providers to actively pursue and develop new forms of organisational form can provide better care more efficiently

Organising and delivering care differently may raise standards and help reduce variation in performance

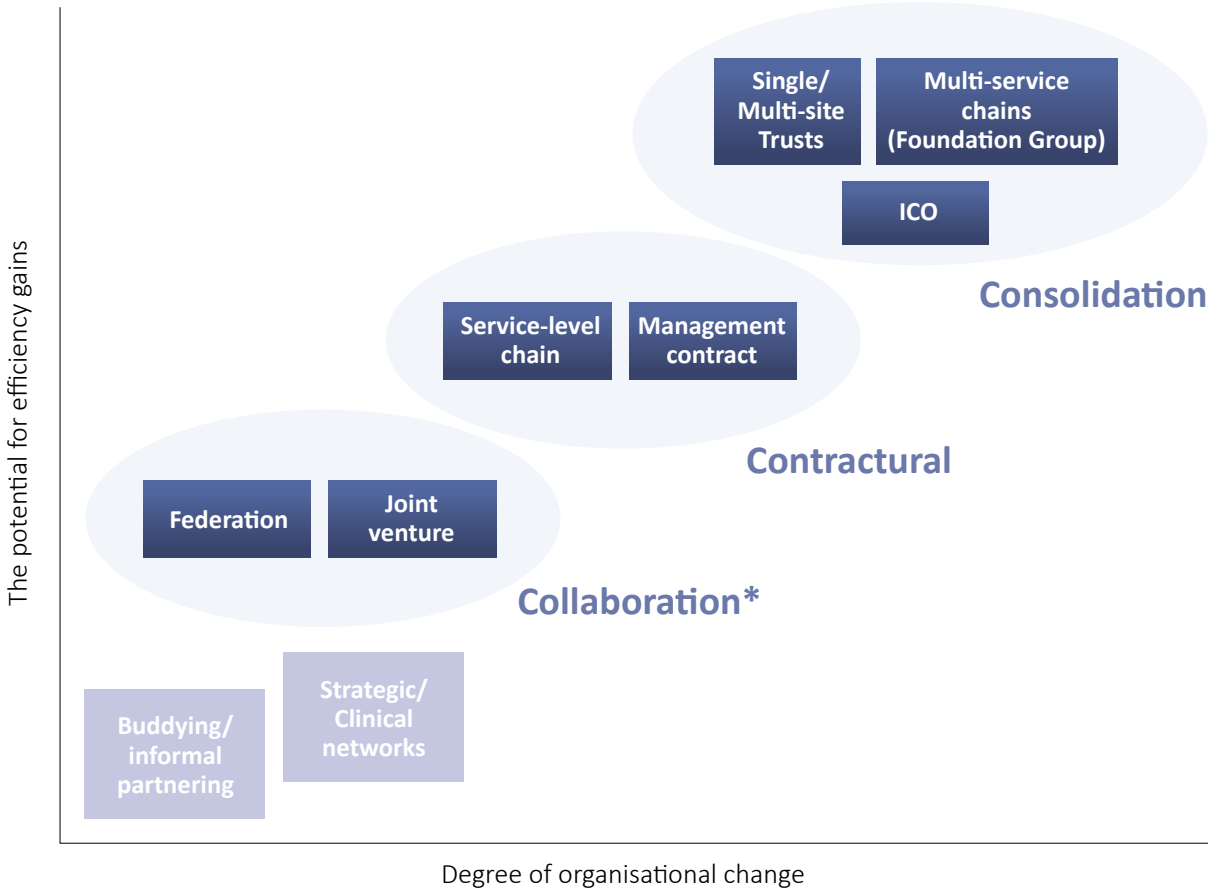
- Variations in performance among providers are wide and persistent, with some organisations having a long history of financial and clinical challenges.
- In a context in which there are increasing concerns about the quality of care providers deliver, looking for ways to organise and deliver services differently to raise standards across the board is critical.
- There is growing consensus in the sector that providers need to adapt and design better service delivery forms in the interests of patients.
- New forms of organising care are likely to require providers to work together to combine skills and capabilities. Greater collaboration, cooperation and where necessary consolidation between providers will often be part of the solution.
- There is an expectation that different organisation forms will lead to greater market influence, increased economies of scale and scope, reduction in duplication of resources and improved efficiency in the provision of services. These and other motivations suggest that there are significant benefits to be derived.
- There are a wide array of options available to providers that should be explored to meet current strategic challenges. There is clearly a considerable learning to be shared from existing innovative practices which are not being spread more widely in the NHS.
- There is no universally optimal form that should be pursued in all circumstances. Creating a permissive environment, removing barriers and enabling organisational change is in the interest of patients and the health service more widely.

The evidence suggests that organisational forms could help drive improvements in the quality of NHS services

- An organisational form/structure defines an organisation through its framework, including lines of authority, processes and systems and resource allocation.
- Organisational change is about adapting to the present and shaping for the future, faster and better than the competition. The ability of an organisation to align, renew and grow, and sustain exceptional performance over time is key to organisation success.
- Changing organisational form can be hard; often needing to shift mind sets requires changing formal systems, structures, processes and incentives.
- It remains challenging to draw systematic comparisons of different organisational forms and the overall existing empirical evidence of the performance of types of healthcare providers is not clear-cut.
- Our evidence suggests that most of the organisational forms reviewed, from collaborative partnerships, to more cooperative arrangements and consolidation could help drive improvements in the quality of NHS services.
- The higher the degree of organisational change, the greater the potential for efficiency gains but also the higher the risk of the benefits being fully realised.
- Common success factors across all the different organisational forms include: strong leadership and good working relationships; a strong and shared focus on quality improvement that can be measured; and a focus on changing organisational culture.

Overview

There are three broad relationship types related to organisational forms – the higher the degree of organisational change, the greater the potential for efficiency gains in organisational forms



- Organisations may **collaborate** without any significant organisation change or cede organisational control such as buddying or clinical networks, as well as more formal collaborations such as federations and Joint ventures.
- At the next level, an organisation may form **contractual** arrangements to share control over one or more elements of its service portfolio, a service level contract or to day-to-day managerial control over an organisation through management contracts and operational franchise.
- Through to an organisation ceding full control, or gaining full control through the consolidation of a merger or acquisition.

Adapted from: Pearson, Jonathan (2011), "Options for healthcare group working", GE Healthcare Finnamore, Available at: http://www.gehealthcarefinnamore.com/insights/10-thought-leadership/13-options-for-healthcare-group-working.html [accessed 8/7/2014]

* Details contained in this pack

Overview

Key considerations addressed in this pack

What are the scenarios in which the form could apply?

Does the form apply across some or all geographical circumstances?

Does the form apply across different health economies?

To what extent does financial and clinical performance determine whether the form is suitable?

What is the role of organisational leadership in the form?

Does the organisational form interact with other organisational forms or is it a standalone form?

Does the form pass the three sense checks:

1. Does it make sense in the context described?
2. Will it make a difference?
3. Is it feasible?

Are the motivations to develop the form primarily defensive or strategic?

Are the barriers to the form primarily technical, strategic or a mix of both?

What support and incentives might be helpful to further the spread of the form?

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Strategic collaborations/alliances allows organisations to share knowledge and practices, and redeploy resources to drive efficiency gains

The evidence suggests there are potential benefits, in terms of improved learning and potential for back office consolidation. However, cultural issues and individualistic tendencies within the partnerships may create risks and act as divisive forces.

Buddying

- Buddying encourages shared learning and drives improvements.
- Buddying is a particular term to describe the support that is available to Trusts that have been put into 'special measures' after serious failures in the quality of care. They are generally 'buddied' with a high-performing partner organisation.
- Buddying as a concept has been generally well received by organisations in special measures, albeit with some notable exceptions (FTN, 2014).
- The evidence suggests it is too early to tell what impact the current buddying arrangements have had on partnering organisations. However, several of the Trusts that have been involved in the buddying process have talked positively about its benefits (Kings Fund, 2014).
- The concept should be extended to include informal partnering where two organisations come together for mutual benefit.

Strategic clinical networks/clinical networks

- Strategic networks are often created by professional groups as a way of diffusing knowledge; disseminating learning and best practice; supporting professional development and to drive the implementation of new ways of working.
- Clinical or learning networks may align policies between institutions but they do not create new integrated delivery structures. Examples include Acute Stroke, Cancer networks.
- In November 2012 building on the success of the previous National Service Framework clinical networks, the National Commissioning Board set out a single operating framework for Strategic Clinical Networks.
- Clinical networks have supported and improved the way care is delivered to patients in distinct areas, delivering integration across primary, secondary and tertiary care (NHS Commissioning Board, 2012).

Overview

Strategic collaborations/alliances are common in the NHS but the degree of success depends on selecting the right partnerships

Buddying	• **Careful choice of buddies is a key requirement.** Mutual respect and trust are key requirements for a successful buddying arrangement. Avoiding competitors and choosing a good operational match from a health economy the buddy has good knowledge of is also crucial (FTN, 2014). • **Buddy arrangements need time for them to make an effect.** Successfully partnering high-performing Trusts with those in difficulty will depend on "allowing sufficient time for hospitals to improve", "support from experienced managerial and clinical leaders in high performing hospitals" and incorporating patient views in order to identify root causes of and solutions to poor standards, and engaging staff to improve staff morale (Ham 2013). • **Partnering with a poorly-performing Trust exposes the other buddy to risks.** "Standards in high performing hospitals may fall" due to executive level time directed into the failing organisation. There are also "reputational risks for supporting hospitals if poorly performing ones do not improve" – the leadership capability in poorly performing hospitals is one caveat as to whether or not buddying can work successfully (Ham 2013). • **Lasting Relationships:** Where good relationships are built, the interaction and partnering between Trusts is likely to continue even after the expiry of formal buddy arrangements (FTN, 2014).
Networks	• **Effective partnerships:** Strategic clinical networks need to develop effective partnerships, for the benefits of patients, with the full range of other structures both within and outside the NHS (NHS Commissioning Group, 2012). • **Informational and learning networks can be unstable**, as they depend on their members commitment to share information with the network. If the network is not "benefit-rich" in terms of being useful and reliable (quality information emerging) it will need reinvention or it will die (Goodwin et al 2004). • **Strong leadership needed:** Informational networks need "key leaders with charisma to engender peer-support" to get prospective members to participate, as the process is time-consuming. A specific individual / organisation should facilitate the network to provide cohesion. (Goodwin et al 2004).

Overview

Hospital partnerships can be more formalised and may operate through relatively straightforward partnership arrangements

Formal partnerships such as federations and joint ventures can lead to new capacity and expertise and sharing of risks as long as there are clear lines of accountability and governance structures.

Federations

- There are a number of different types of federal organisations with different levels of cooperation and intensity. Overall they seek to share resources, make efficiency savings, and provide benefits to every member of the group without reducing organisational sovereignty.
- Federations can have standardised care pathways, share data and pool resources and back office services, and are governed by a Partnership Board comprising of representatives from partner organisations.
- Examples in the NHS include Academic Health Science Networks, and the Southern Sector Partnership in South Manchester.

Joint Ventures

- Joint ventures include arrangements where two or more organisations form a new structure with shared equity and governance to provide services. There are two different types of legal form that could be used – corporate joint ventures (shared services agreement) and contractual joint ventures – with differing levels of risk sharing.
    - **Corporate joint ventures** (shared services agreement) enable organisations to gain access to new capacity and expertise, greater resources and sharing of risks. However, the advantages can be offset by unclear governance and lack of genuine commitment
    - **Contractual joint ventures** can operate through relatively straightforward contractual arrangements whereby one partner undertakes to deliver a specific service to the other or by setting up a special purpose vehicle.

Overview

For collaborative partnerships to succeed, clear governance and lines of accountability need to be in place

Federations	• **Federations offer several benefits, but close cooperation can also bring risks.** Collaboration, efficiency, innovation, sharing of best practice, financial management and contractual independence can be improved by joining a federation, and specialities can be developed and leveraged for the benefit of the group. However, close cooperation means differences in culture, individual drivers and other requirements between the members are a potential risk (Pearson, 2011). • **It can be difficult to build a federation due to conflicting organisational interests within it.** Hospital and clinical networks (e.g. federations) are conflicted between the individual organisation commitment of hospitals and clinicians and the need for the federation to establish its own identity. Dedicated clinical and administrative leadership, joint clinical governance framework is crucial, and ongoing support is needed until the network is fully established (Goodwin et al, 2004). • **Federations may be particularly useful in rural locations.** Hospital networks can help in sharing risks and costs between providers under financial pressure, helping small hospitals to survive – "remote rural locations where costs of provision are high and traditional hospital care not financially viable" can benefit in particular (Goodwin et al, 2004). • **Full integration of federations is difficult and practically non-existent in the NHS.** Major challenge for Academic Health Science Centres (AHSC) and Networks (AHSN) is the separation of accountabilities for patient care, research and education in different government agencies, preventing universities and healthcare providers from "cross-subsidising academic and clinical missions and from creating fully integrated AHSCs and AHSNs" (Ovseiko et al. 2014).
Joint Venture	• **Relationship between joint venture partners is crucial.** Effective partnerships and joint ventures dependent on the quality of the working relationships between the organisations involved – these relationships are facilitated by "more decentralised management structures and effective performance management" (Hackett 1996 cited in Kings Fund and FTN, 2014). • **Commitment to the success of the JV is needed**, with focus on joint benefits rather than individual partner objectives. Managerial responsibilities should be divided as "according to the functional expertise of each partner" (Beamish and Lupton, 2009). • **Governance model must be appropriate.** Joint ventures can be "perceived as a 'win-win' solution for the organisation involved" as they do not involve changes in ownership structures. Key issue is to ensure appropriate governance model to manage shared financial and clinical risk, and clarity on lines of accountability (Kings Fund and FTN,2014). • **Joint ventures are inherently unstable.** Success of a JV may encourage one partner to leave the JV to compete with others. Changes in partners conditions, strategic missions, their bargaining positions and in the importance of the JV to them, as well as changes in the environment and competitive environment can all serve to initiate one partner leaving the JV. (Harrigan, 1986).

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Overview

We have found that examples of most of the organisational forms already exist in the NHS, while multi-service chains and ICOs are more common in other health systems

The logos above represent many of the organisations visited or considered by the Dalton Review team during the evidence gathering for the purposes of the development of the recommendations of the Review. This does not represent or indicate endorsement by the Dalton Review.

Overview

There seven forms described in these evidence packs which are applicable in different contexts and in different types of health economy

Form	Potentially applicable to…
Federation	**All geographies and most Local Health Economies (LHE) circumstances for sharing back office functions and performance improvement activities, significant sharing of clinical resources more likely to be limited to regional and contiguous. Unlikely to be a suitable response to serious financial difficulties.**
Joint venture	**Densely populated areas where, subject to demonstrating patient benefit from increased scale and focus of JV, activity can be consolidated without significantly impairing patient access to services.**
Service-level chain	All geographical and LHE circumstances. Dependent on the organisation's ability to replicate operational practices/standards on new sites and having necessary capability and capacity to run services on distant sites. May be better suited to specialties or services that are relatively self-contained; where patients are likely to cross service boundaries between host and outreach organisations there are significantly greater challenges with clinical governance and accountability.
Management contract	Suitable for situations where poor clinical and/or financial performance can be transformed through change of control of some or all of the organisation's assets. These are time-bound arrangements with control being temporarily transferred to another organisation with sufficient management expertise and possibly some economies of scale. Not suitable where organisations are fundamentally unsustainable without major service reconfiguration in LHE.
Multi-site Trust	Currently exists in all geographical and LHE circumstances, though may not be clinically and financially sustainable in some areas without significant service change and/or diversification. Expansion largely relies on ability to consolidate services, having demonstrated patient benefits, may be better suited to urban and suburban areas.
Multi-service chain (Foundation Group)	All geographical and LHE circumstances including non-contiguous configurations. Dependent on the ability of the Foundation Group to replicate operational practices/standards on new sites and having necessary capability and capacity to run services on distant sites. May be better suited than multi-site trust to acquiring new sites with limited potential for service rationalisation, probably less suitable for acquiring sites with significant financial problems and/or where LHE faces fundamental problems.
ICO	LHEs with a relatively large and well defined group of high-intensity service users have most potential benefits. Significant diversity of provider configurations, types of provider, contracting mechanisms and populations served means potentially applicable in any geography or LHE with sufficient potential to improve value for patients. Unlikely to be suitable response to short to medium-term financial issues given longer period to realise return as "integration costs before it pays" (Leutz,1999)

Overview

Each of the organisational forms offer a different set of potential benefits…

Form	Potentially benefits
Federation	**Sharing of best practice and alignment of patient pathways to improve outcomes and operational efficiency. Potential to share clinical resource and expertise and some back office functions to realise economies of scale.**
Joint venture	**Focus on managed services may lead to improved outcomes and operational efficiency. Access to skills and expertise of partner organisations and ability to separate risks borne by joint venture from partner organisations. Able to reinvest surplus directly into new equipment, upgrades and innovation if a separate corporate identity, giving staff greater feel of ownership over quality/cost improvement. Could be used to create a hub for developing specialist expertise that could give rise to a service-level chain. May help partner organisations to meet the quality standards over seven days through the pooling of the clinical workforce.**
Service-level chain	Local access to expert specialist provision, ability for host provider to realise economies of scope through focus on core services, association with a specialist brand and income from outreach organisation. Outreach organisation spreads own brand, income creation opportunities, potential economies of scale and scope. May improve quality through the standardisation of clinical practices, protocols and procedures.
Management contract	Asset light way to allow alternative providers to deliver services to a population. Access to previously unavailable expertise providing financial control, standardised processes, some consolidation of non clinical functions. May address capacity or capability issues to allow focus on core site functions, or offer method of expansion through partnership with property or operating company.
Multi-site Trust	Possible economies of scale through service rationalisation and unified and support functions. Ability to move staff between sites to meet changing demand and share expertise.
Multi-service chain (Foundation Group)	Improved quality and operational efficiency in new sites by standardisation and replication of proven operating frameworks, procedures and policies developed on existing sites. New sites benefit from strategic leadership, higher standards and support structures offered by the Foundation Group and may realise economies of scope through greater focus on operational management. May be possible for Foundation Groups to operate in situations that would be unsustainable for some standalone providers.
ICO	International examples have demonstrated improved patient outcomes and cost savings. Incentives such that care provided in most appropriate setting, focus on prevention and maintaining health, aligned patient flows.

Overview

…and achieving those benefits comes with a different set of barriers and challenges for each organisational form

Form	Potentially barriers
Federation	**Maintenance of organisational sovereignty may require reliance on consensus decision making, so significant strategic change may be difficult. Perceptions of competition regime may discourage cooperation, though competition only likely to be an issue in federations that are driving anti-competitive behaviour that has weak benefits for patients.**
Joint venture	**Lack of expertise in NHS bodies in contractual negotiations so may require expensive external advice. Regulatory and approval mechanisms for joint ventures commonly perceived as barriers, but Monitor do not need to approve less than 25% of change in income. Where consolidation results in reduction in competition there is a need to demonstrate requisite patient benefit.**
Service-level chain	Geographical distances can make quality and performance management more difficult as smaller scale means decentralised management structure less viable. Transition from single site centre to a hub and spoke form can be complex. Potential brand reputation damage if associated with bad practices at host or by outreach organisations.
Management contract	Difficult to establish and maintain appropriate governance and accountability. Where there are wider issues meaning the site will never be financially viable in its current form, the contractual constraints will not allow for significant enough change to alter this.
Multi-site Trust	Normal barriers to acquisition and accompanying service change, i.e. consumes significant management energy, so the Foundation Group needs to have sufficient leadership headroom to devote to integrating the acquired sites as well as being able to maintain its own performance. Change of ownership may fall with in competition regime, not as restrictive as perceived but need robust demonstration of patient benefits.
Multi-service chain (Foundation Group)	Normal barriers to acquisition, i.e. consumes significant management energy, so the Foundation Group needs to have sufficient leadership headroom to devote to integrating the acquired sites as well as being able to maintain its own performance. Plus need to replicate the operating framework, procedures and protocols on other sites and be able to undertake the cultural change required to integrate new acquisitions. Geographical distance means effective decentralised management structure required.
ICO	Integration is not a quick way to save costs and should primarily be a way to improve outcomes and patient experience. In the short term integration usually requires investment and may see ROI only in the longer term and length of contract duration needs to be longer than the current three years for this to be worthwhile. Accurate data on patient flows, pricing and outcomes is required and is difficult to align IT and information systems to gather this reliably. Action and agreement on the commissioner side is also required to enable these forms to emerge more widely and effectively.

Overview

There are also differences between how the forms are registered and inspected by CQC…

	CQC registration held by	CQC inspection of
Federation	**If it creates a new legal entity, this must register in own right. If not, included in existing registration of each organisation in the federation.**	**Locations specified in the new or existing providers' registration.**
Joint venture	**If it creates a new legal entity, this must register in own right. If "pooled sovereignty", included in providers' existing registration.**	**Locations specified in the new or existing providers' registrations.**
Service-level chain	Provider (e.g. Moorfields).	Provider main location(s) plus service lines in the chain normally inspected separately, timed to coincide with inspection of their 'hosts'.
Management contract	Provider – the legal entity responsible for the service (e.g. Hinchingbrooke, rather than their management contractor).	Locations specified in the provider's registration.
Multi-site Trust	Acquirer, or a new organisation created by merger.	Locations specified in the provider's registration.
Multi-service chain (Foundation Group)	Provider (e.g. BMI or Care UK).	Locations specified in the provider's registration.
ICO	Provider (however configured).	Locations specified in the provider's registration.

Overview

The application of competition law may also vary between organisational forms, but depends on changes in control

Archetype	Competition Considerations
Federation	The key question is whether the transaction gives rise to a change of control over the activities of a business. Transactions or agreements which would result in a change of control over all or part of a provider's activities (employees, assets or rights and liabilities), and which are above certain thresholds, may be subject to merger review. A merger can mean an acquisition, joint venture, transfers of service, asset swap or a management agreement between two separate providers. Mergers are only likely to raise competition concerns if patients and/or commissioners see the merging providers as important alternatives to each other (for example, because they are located close to each other or provide similar services) and there are few, if any, other providers patients could use. In relation to anticompetitive behaviour, Monitor's licence prohibits agreements that could have the effect of preventing, restricting or distorting competition but only to extent that they are against the interests of patients. For example, providers could decide amongst themselves which services they will stop providing to a commissioner. This sort of agreement could be to the detriment of the commissioner and the patients they represent. However, where agreements are in the interests of patients then these would be allowed even if anticompetitive.
Joint venture	
Service-level chain	
Management contract	
Multi-site Trust	
Multi-service chain (Foundation Group)	
Integrated Care Organisation (ICO)	Vertical integration is less of an issue than if two competitors merge as there is no duplication of services. There may be issues in relation to a gatekeeper role (i.e. could refer to themselves) which would be considered under the provider licence.

Useful guidance – Monitor and CMA short guide for managers
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/339830/CMA-MonitorShortMergerGuide-1.pdf
CMA guidance for organisations starting or going through the process https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/339767/Healthcare_Long_Guidance.pdf

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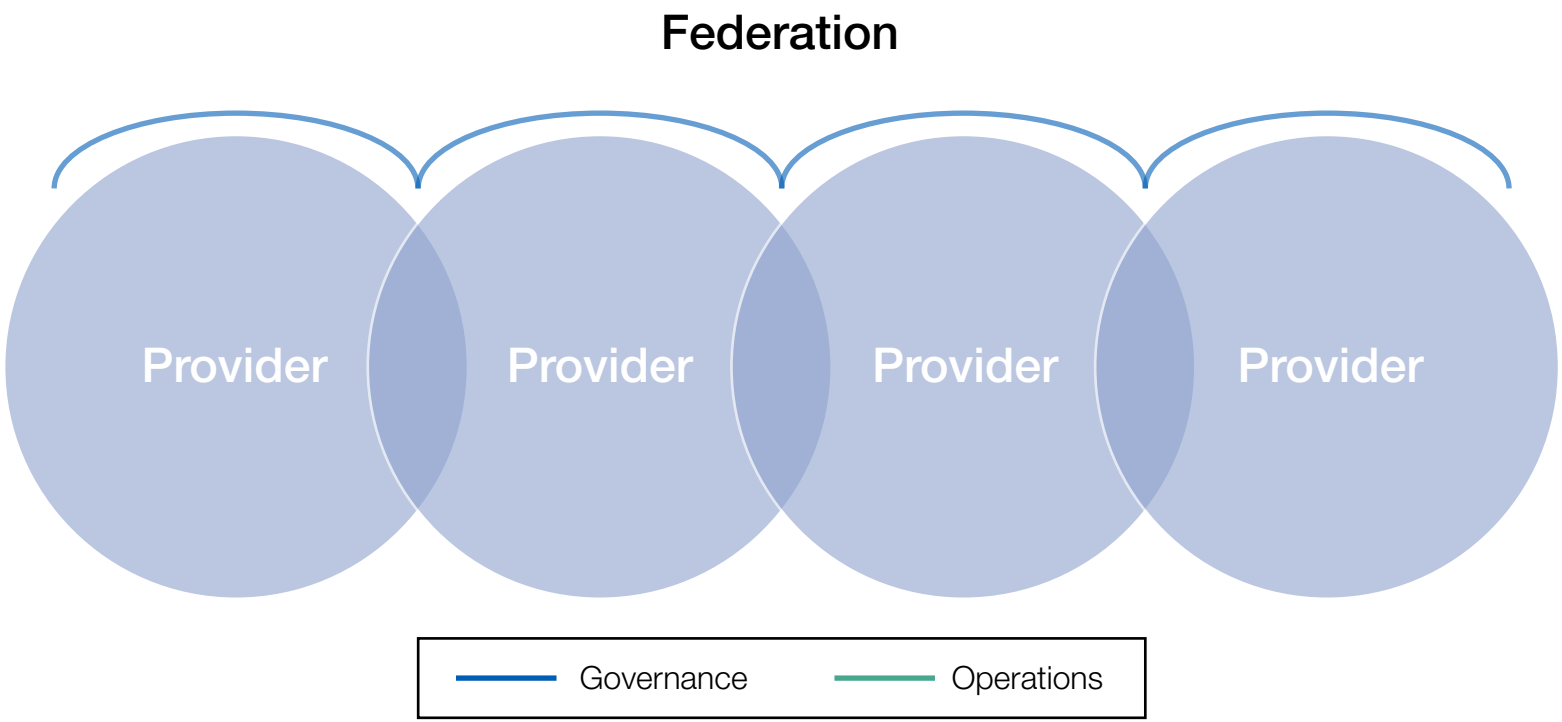
Federations

What is the form?

What is a Federation?

A framed network or collaboration across multiple partners and sites, whilst allowing the retention of the values and principles of the partners.

Examples include the Southern Sector Partnership in South Manchester, UCLPartners, and other Academic Health Science Networks.



What is the form?

Federations can be an effective means of making clinical improvements and financial savings without conceding organisational sovereignty

Organisational sovereignty	Assets	Intangibles	Range of services	Scale
Individual sites in the federation retain almost all of their sovereignty, ceding only select functions to the group.	Assets retained by each partner. Only movement in estates or back office rationalisation.	Standardised care pathways, the sharing of data and the potential to pool procurement resources.	Form dependent.	Largely regional, but the potential exists for non-contiguous national federations.

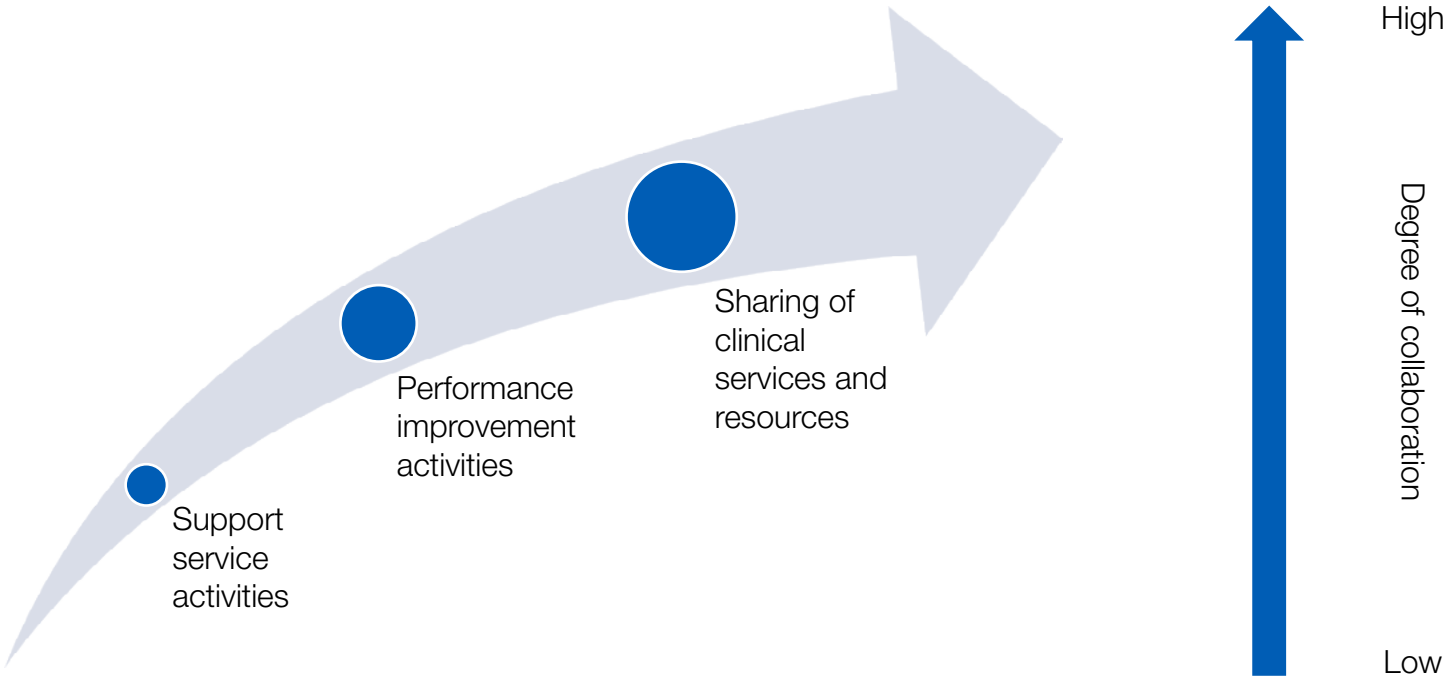
Key features:

- There are a number of different types of federal organisation possible – all with different levels of cooperation and intensity.
- They are typically set-up by means of a memorandum of understanding.
- Federations seek to share resources, make efficiency savings, and provide benefits to every member of the group.
- This is without the change of organisational sovereignty which is associated with other forms such as joint ventures, or Foundation Groups.
- Has the potential to achieve large financial savings through the consolidation of back office services.
- Not geographically defined – typically regional and contiguous, but are capable of forming national structures.
- Federation managed by a partnership board, consisted of representatives of all the member organisations.
- Defined corporate strategy, not organic expansion.
- Competition issues if certain specialisms are consolidated into one of the partner Trusts. However, is a strong patient benefit case can be made, competition regulation can make allowances.

What is the form?

Different degrees of federal collaboration

There are many different degrees of federal structure, all of which share varying services with the other member organisations, each of which entail a varying degree of collaboration. The more collaboration that is required, the more emphasis the governing body musty put on the relationship between its member organisations.



What is the form?

There are a number of different degrees of federal collaboration, all of which make different demands on senior leadership and resources

Support service activities:

Least intensive

- **Human resources:** There are considerable financial benefits which can be realised by a federation which looks to consolidate human resources. The degree of total group savings, money which could be reallocated to clinical services, increases with the size of the federation. However, in order to execute this change, often a joint venture will be required as more formalised governance structures are required.
- **Procurement:** There are already a number of procurement initiative networks in the NHS, such as the London Procurement Partnership and the North West Collaborative Agency, all of which are able to share data and pool buying power to get a better deal on their purchasing.

Performance improvement activities:

More intensive

- **Performance management/benchmarking:** Trusts/FTs clinicians coming together to establish common clinical standards is a common feature of international multi-service chains like Humanitas, Italy, who share clinical benchmarks across 6 hospitals. However, it requires nothing more than informal collaboration and is well within the purview of federations. This would allow the cultivation of a federal identity and the development of group excellence in a framework of mutual support.
- **Standardised care pathways:** There is also the opportunity to standardise patient care pathways and make tangible improvements to service delivery without the need for major organisational overhaul or more formal legal contracts, as the Southern Sector Partnership in South Manchester have attempted.

Sharing clinical services and resources:

Most intensive

- **Telemedicine:** Whilst widely used in India and the United States, the opportunities afforded by telemedicine have been largely unrealised in the UK. Trusts unable to acquire a resource on their own can jointly acquire a clinical resource and share it electronically, with, for example, a consultant on call via Skype. This can help to overcome the recruiting problems some small, isolated hospitals suffer from.
- **Consolidating specialisms:** In contiguous federations, organisations can cede certain services, such as oncology, to the member of the federation which is best placed to execute that specialism on a wider basis, and potentially on behalf of the whole group, benefiting from the input of other members of the group. This is most appropriate in a large urban centre, with contiguous trusts all providing the same services. A federation could realise cost efficiencies by eliminating the need for service duplication. However, there may be competition issues associated with this approach and CMA consultation on a case-by-case basis should be undertaken.

What is the form?

Regardless of the services it shares, a federation will be run by a Partnership Board with representation from each member of group

The level of formality of this managerial board is dependent on the level of collaboration entered into and on which services are being shared. Evidently, there would have to be clearer, more formal lines of accountability for federations operating telemedicine services, or sharing clinical resources.

Partnership Board	**Partnership Board:** • A Board of representatives from each of the federation's constituent members. • Headed by a CEO – sometimes this CEO position is on a rotating 6 month basis, so as to ensure equal representation for each of the members. • However, this is largely flexible entity in its size, scope and authorities, configured to best suit the benefits being sought by the federation. • The Partnership Board also set the strategic goals for the federation, defining its ongoing role and scope.
Member Organisations	**Each site in the partnership would retain organisational sovereignty:** • All systems of governance would remain in place at an individual site level, undisrupted by the formation of a federation and entailing no loss of organisational sovereignty, save that which is willingly pooled. • Responsibility for any services pooled by the group would be managed by the Partnership Board, who would also monitor its performance and delivery. • Directors appointed by, and accountable to, the Unitary Board of Directors.

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Federations

Case study

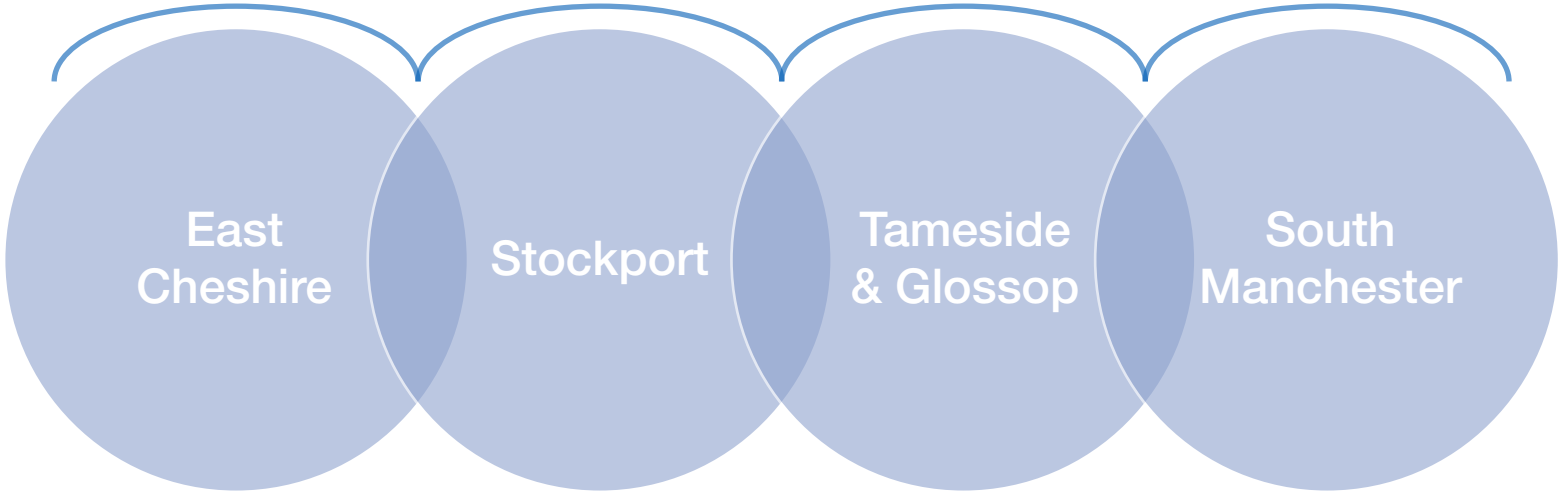
The Southern Sector Partnership, South Manchester

Southern Sector Partnership

The Southern Sector Partnership is a collaboration between four trusts set up in response to the need to improve patient outcomes/ quality of life and also to achieve more with less: East Cheshire NHS Trust, Stockport NHS Foundation Trust, Tameside Hospital NHS Foundation Trust and the University Hospital of South Manchester NHS Foundation Trust.

The Partnership is underpinned by a memorandum of understanding, led by a programme director and a board with executive level representation from all four organisations. The partners have shared aims for collaboration (see next slide) but also have the option of taking a 'pick and mix' or affiliate approach to the initiatives they sign-up to. They may also work with other trusts where this is in the best interests of patients.

The Partnership cooperates with broader commissioner-led initiatives that are responding to major structural challenges in delivering high quality services in financially sustainable ways. These include the South Sector Challenged Health Economy (SSCHE), Healthier Together (Greater Manchester), Caring Together (East Cheshire) and Care Together (Tameside).



Case study

The Southern Sector Partnership is taking a collaborative approach to deliver both clinical and financial improvements

Clinical

Streamline and standardise clinical pathways

- Clinicians from all Trusts brought together to work-up options for single care pathways for patients.
- Aims to standardise care pathways across the organisations in order to improve patient experience and outcomes.

This involves the sharing of certain services between Trusts

- Sharing of certain specialist services to avoid duplication over a small geographical area.
- This also allows the pooling of clinical resources – potentially facilitating improvements in services.
- This includes trying to centralise technology services such as Electronic Patient Record (EPR), minimising duplication.

Financial

Shared procurement and supply chain management

- Group structure enables a large amount of clinical data to be gathered, all of which can be used to inform a collaborative procurement process.
- Working together on procurement would also allow the group to leverage economies of scale.

Consolidated/improved shared working in back-office functions

- Potential for shared back office processes.
- Reinvest the savings to realise other planned transformations in clinical services.

Decentralised management

- Delegated Authority from the individual Trust Boards.
- Autonomy of individual hospitals maintained.

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Federations

Key considerations

Does the form apply across some or all geographical circumstances?

Federations are such a flexible form, there is arguably a form of federation which is applicable for every geography, from contiguous urban trusts, through to small, isolated, rural DGHs. Ultimately, the geographical restrictions on a federation depend on what type of property/services are being brought under the banner of the federation: physical, or intellectual. If physical, such as service sharing, the importance of contiguity is greatly increased.

For example:

Contiguous FTs/Trusts: (*Support Service Activities, Performance Improvement Activities, Sharing of Clinical Services and Resources*)

- Local area and short travel times for senior management and clinicians, increasing the likelihood of effective and ongoing cooperation.
- Support service activities can very easily be rationalised between contiguous trusts, as the presenting challenge is much reduced.
- Service sharing is enabled by the contiguity of the Trusts. Potential to realise major clinical efficiencies as a federation could reduce the duplication of specialist services in Trusts within a short distance of one another enabling challenges such as the continued delivery of quality standards over seven days, to be realised.
- Pooling clinical expertise, high patient flows and the consolidation of data also has the potential to realise large clinical benefits.
- Competition regulation could be a consideration and self-assessment against the lessening of competition should be undertaken by the organisations.

Network of coastal DGHs: (*Support Service Activities, Performance Improvement Activities, Sharing of Clinical Services and Resources*)

- There is potential to employ mobile specialists, who work for a number of different Trusts according to where they are needed. This would reduce the need for small hospitals to provide the a full range of services themselves, whilst still being able to offer those services to patients.
- Federations provide the platform for clinicians from different organisations to collaborate.
- Telemedicine could be deployed to further realise both clinical and financial efficiencies.

Non-contiguous federations: (*Support Service Activities, Performance Improvement Activities*)

- Academic Health Science Networks also operate in non-contiguous groups. Their loose arrangements, based on the sharing of intellectual, not physical property allow for a wide geographical spread of members.

Key considerations

It is important to be clear which restrictions apply and when

There are examples in the NHS of very successful federations at either end of the geographical scale.

- Academic Health Science Networks are examples of federations spread across an extremely large geography.
- In contrast he Southern Sector Partnership is set up across a small number of Trusts in close proximity in the Greater Manchester area, operating across a defined health economy.
- It is very important to define the scope of the federation; the services or functions the members seek to share will determine the difficulties they might face in operating across geographies.
- Small, isolated coastal/rural DGHs sharing clinical resources to actively seek to overcome geographical barriers and bring together their understanding of each others' challenges to deliver better outcomes for patients. This type of federation is a means of potentially overcoming the geographical challenges of a group of isolated trusts.
- Others – such as federations which look to share support services – are not confined by geography at all, and it should not be seen to be a barrier: back office can be consolidated in both contiguous and non-contiguous organisations.
- More involved federal forms such as sharing of service provision would struggle to operate over a larger geography given the dependence on consistent patient flows. It would also be a resource intensive process to manage such an enterprise, with management and clinicians having to travel large distances on a regular basis.
- There would also be a potential negative impacts on the local population by pooling a specialism to a single Trust in a federation which is non-contiguous due to potential access travel times for patients.

Key considerations

Whether the federation form applies across different health economies is dependent on the services it seeks to collaborate on

The federation form applies across different health economies dependent on the services involved

- The only form of federation in which the influence of different health economies would be a major factor is a form in which services were consolidated within a federation.

If this were to happen, particular attention would have to be paid to the effects such service consolidation would have on the patient access to services, and whether the local area would be best served by one single service, as opposed to keeping that activity with the base trusts. It must be a service change that actively seeks to benefit the local health economy, and is not a decision made purely for the financial interests of the respective Trusts; the patient benefit test is key. With regard to the CMA, the following further points apply:

- The consolidation of services between Trusts may be anti-competitive if it can be judged to have an appreciable affect on competition.
- However, it is unlikely to infringe on competition law if the new entity's share of the relevant market is less than 10%.
- If the new entity's share of the relevant market exceeds 10%, it may still be exempt from UK and EC provisions against anti-competitive agreements.

Ultimately, however, the CMA will judge each case on whether it is able to improve the services patients receive or not. The test is always whether patient benefit outweighs loss in competition. Trusts looking to form a federation must be able to demonstrate this.

Key considerations

Does the form apply across different health economies?

- A federation could present an extremely attractive option for struggling providers, with the potential to make financial savings which could then be reinvested in service provision.
- Examples of this include support service or back office rationalisation or Trusts collaborating to pool their clinical workforce and rotas to enable them to meet quality standards over seven days.
- There is no reason why a struggling provider, as opposed to a successful one, could not partner with other providers and look to consolidate back-office and HR.
- Organisations that have very large financial problems and/or those located in local health economies that face significant challenges beyond the boundaries of the organisation may not be suitable to become part of a federation that is looking to share more than simple back office procedures.
- The sharing of services, for example, would require a considerable upheaval on a number of fronts, both clinical, financial and in senior management resources; as such, struggling providers would not be best placed to undergo such a procedure.
- Furthermore, benefits could take a period of time to realise so may not be a suitable option for a struggling provider looking to keep risk off their books.
- Lower performing organisations in federations with higher performing organisations can benefit from the stronger leadership, higher standards and support structures offered by the group.
- This may include organisations that are clinically and financially viable but need to improve standards or viable organisations that are poorly led. Partnering has the potential to be expanded in future within the informal boundaries of a federation – an environment in which sovereignty is not ceded, and where intellectual property can be shared.

Key considerations

NHS Trusts and Foundation Trusts have the ability to form a federation. However, the independent sector would be unlikely to be involved

Foundation Trusts

- Both FTs and NHS Trusts have the power and freedom to form federations for a range of services.
- FTs have powers under section 47 of the NHS Act 2006 to take action which appears to it to be necessary or expedient for the purpose of or in connection with its functions. This includes entering into contracts and acquiring and disposing of property.
- NHS Trusts have identical general powers under Paragraph 14 of Schedule 4 to the NHS Act 2006.
- As such, both NHS Trusts and Foundation Trusts are free to enter into a federation, providing that the proposal meets CMA standards.

Independent Sector providers

- The independent sector would be unlikely to get involved in a federation because it would be difficult to prove the benefit they would be able to extract from the federation, especially given the lack of a legal mechanism to realise such a process.
- Partnering with the independent sector is much more common in health joint ventures for this very reason: it provides a legal mechanism for the extraction of value from the arrangement.
- With a federation, intellectual property and capital would be contributed by the independent sector partner without the concrete guarantee that they would be able to have a stake in later decision making processes. This makes such an investment risky and unlikely to be considered.

Key considerations

Does the form apply to a single service, a limited range or full multi-service organisations?

This archetype is extremely flexible and could apply to a range of different services – from single service through to many. It is, however, very unlikely if not impossible that a federation would be a vehicle to create a new full multi-service organisation, given the lack of legal documentation the form has to structure itself upon. Executing any sort decisions at such a level would be impossible.

However, there are major benefits to this lack of structural integration:

- In particular, this avoids any risk of organisations being wary of collaborating because of a fear of being subsumed into the group, or by certain more successful hospitals within the group – a major cultural barrier to the organisational change involved in multi-service chains, for example.
- This informality could allow members of a federation to realise some of the benefits a multi-service chain realises, without having to confront the issues of sovereignty and legal acquisition that a chain includes.

Federations sharing services:

- The services which could be shared would be limited to a range of specialisms or back office which, in a given number of contiguous Trusts , were duplicated to the extent that the clinical and financial benefits to be gained from pooling services are clear and presentable.
- These are likely to be specialisms with typically low patient flows, and which would benefit from pooled expertise.
- For small, isolated, coastal DGHs looking to share clinical staff, or employ telemedicine through a federal form, the parameters are broadly similar; the introduction of the federation could help the organisations to reduce diseconomies of scope.

Key considerations

What is the role of organisational leadership in the form?

- Effective leadership and management of relationships between the member organisations has to make up for the lack of legal mechanisms that the organisations have available to them and therefore strength of relationship and degree of trust on the Partnership Board is crucial.
- Typically, in a federal form, one of the member organisations takes a lead in initiating the process of forming a federation between a number of Trusts including agreeing the lead for governance, quality and finance.
- However, given that the federation will almost always only pertain to certain services or functions, senior management of the Trusts will not lead the project.
- Instead, an independent project leader will usually be appointed to execute the establishment of the federation. The aim of this is to provide an independent, strategic perspective on the federation, and to enshrine the sense that the federation does not entail the takeover of one Trust by any others.
- Trusts will freely enter into the federation with a clear objective as to what they are looking to gain from the federation, and what will be under the power of the federation to execute and govern.
- Ultimately, it is the quality of the relationships within the federation which matter the most.

Key considerations

Does the form interact with others or is it standalone?

Federations are a form which invites interaction with other forms as a result of its inherent flexibilities and because of the way it engenders organisational cooperation:

- By encouraging collaboration across NHS Trusts/FTs, federations can provide a fertile ground for service-level innovation and the development of opportunities which, without the federation, would have remained unfulfilled.
- Given that many federations already look to share or pool services between their organisations, joint ventures are a likely further nexus for such an interaction.
- For example, the consolidation or outsourcing of back-office and HR would most likely require a joint venture in order to properly execute the process. The rationalisation of estates in a federation would also be likely to require the formation of a joint venture.

Key considerations

Which primary motivations does this form work best for?

The motivations for developing a federation are a mix of strategic and defensive. The formation of a federation may be expected to be driven by desires to:

- Eliminate duplication in back-office and make quick, easily realisable financial savings on back office and HR.
- Share intellectual property and care pathways across a number of different trusts, with the aim of working together and benefiting from the best practice of other bodies.
- For small, isolated, rural DGHs, motivations will be primarily defensive, whereby they use the group power of the federation to protect themselves from financial and clinical pressures that they'd be less well placed to deal with on their own.
- This includes the sharing of clinical resources across more than one site, making up for the financially inefficient duplication of a resource which could be used in more than one organisation.
- This extends to the use of telemedicine, whereby a federal structure would enable trusts to work together and share resources in a way that would not otherwise be possible. There is no geographical restriction on this. Indeed, a notable use of telemedicine in the UK at the moment is in the Orkney Islands, where nurses, if required, are able to use high-resolution video equipment to provide information to a consultant in Aberdeen, hundreds of miles away, who can advise them on appropriate interventions where required.

Key considerations

Are the barriers to the form primarily technical, strategic or a mix of both?

A mix of barriers currently exists to developing federations in the NHS:

- There is a lack of a legal mechanism to drive change agreed at board level but not enacted on the ground.
- There can be a challenge regarding historical relationships between neighbouring organisations that may mean that a federation based on trust rather than a contractual arrangement may not have robust enough governance arrangements.
- As such a federation looking to share services must have the capacity and scope to drive transformational change. In order to do this there must be a clear sense of shared purpose and aligned goals. If there is doubt that the federation will be able to execute service sharing due to resistance or divergent objectives, then alternative forms may be more appropriate.
- The legal barrier to the formation of a federation extend only to when services are being shared, at which point the CMA would look at the situation on a case by case basis.

Key considerations

Does the form pass the three sense checks?

Does it make sense in the context described?	• There are already a number of federations in the UK and the largest of these, Academic Health Science Networks, are very well established and successful organisations. • What is missing is awareness of the benefits the federation form can bring – and indeed the range of options it can offer to providers.
Will it make a difference?	• There is already excellent evidence from Academic Health Science Networks that the best examples of federations can combine two attractive features for NHS organisations: the sharing of expertise and information with the retention of organisational and operational sovereignty.
Is it feasible?	• It is, on paper, extremely easy to set up a federation, with many current federations dependent on little more than a memorandum of understanding to codify their organisational brotherhood. • However, the looseness of its legal underpinnings puts a great deal of pressure on the relationships between the body members. • So whilst it is very much feasible, a keen appreciation of the pitfalls of forming federations, and the importance it puts on effective relationships, is very important if organisations wish to execute the form successfully.

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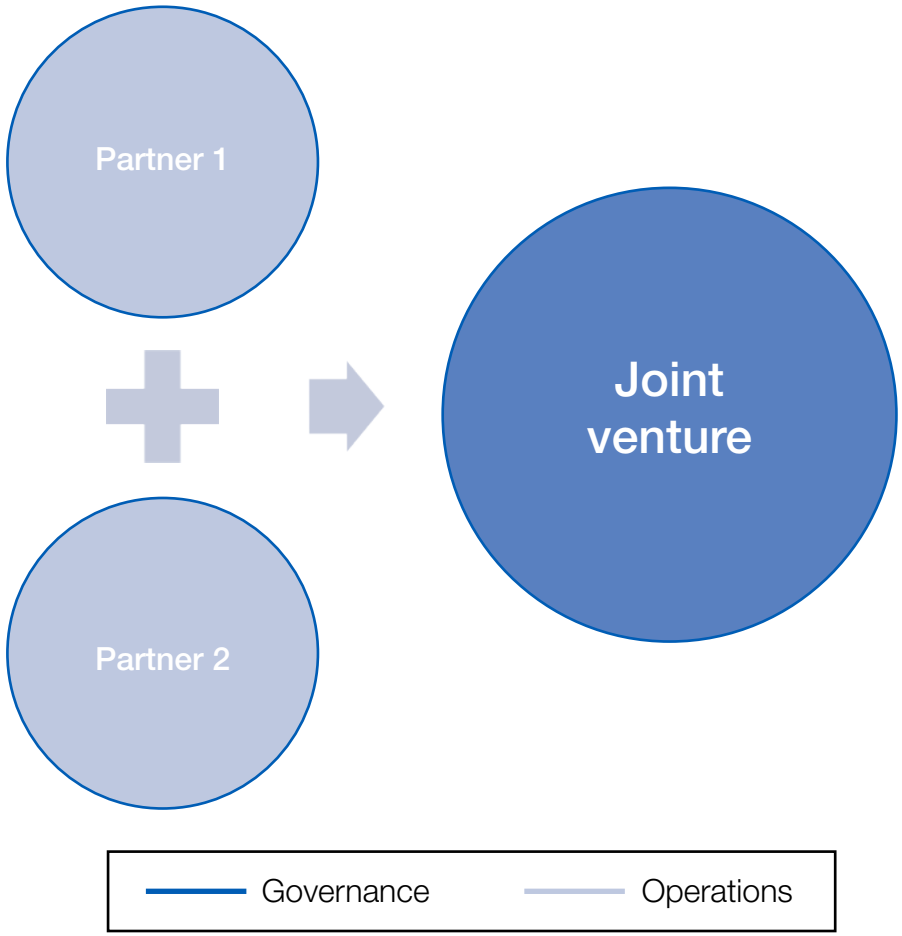
Joint ventures

Joint ventures

Joint ventures, or shared service agreements, are where two or more organisations form a new structure with shared equity and governance to provide services



What is the form?

Joint ventures can both leverage economies of scale, and eliminate diseconomies of scope in trusts unable to generate sufficient volumes in services

Organisational sovereignty	Assets	Intangibles	Range of services	Scale
Single entity with a managing board and a degree of operational sovereignty dependent on its legal status, with ownership shared by two or more partners.	**Corporate joint venture** A corporate joint venture, involves establishing a separate legal entity in a special purpose vehicle, with shared risk. **Contractual joint venture** In a contractual joint venture, the assets can be owned by one single organisation, who takes on all the associated risk	Able to leverage economies of scale as well as eliminate diseconomies of scope. Also enables standard care pathways and better data collection.	A single joint venture will almost always pertain to a single service. A narrow purpose is very important. However, the range of services for which a JV could be employed is wide – from elective surgery through to property services.	Regional, but potential to become a hub for a service-level chain.

Key features:

- They can become efficient, high-volume centres, able to collect excellent patient data.
- Joint ventures that are a separate legal entity; they are able to reinvest surplus directly into new equipment, upgrades and innovation.
- Initially geographically defined to the location of the partners. No geographical limit on the expansion scope of an already successful joint venture into a service-level chain.
- A Partnership Board, consisting of representatives of each of the partners, exercises strategic leadership and sets quality and financial frameworks.
- Competition regulation may be an issue if a joint venture is unable to demonstrate a patient benefit case which outweighs any reduction in competition.

What is the form?

There are many different types of joint venture in the NHS, reflective of the wide range of functions a joint venture can be used to support, including but not limited to the following:

Pathology

- Viapath
- UCLH Pathology
- Southwest Pathology

Technology Services

- UCLH Imaging Services

Elective Surgery

- Elective Orthopaedic Centre
- The Christie Clinic

Property Services

- Calderdale and Huddersfield NHS FT and Henry Boot Developments Ltd.

Research and Education

- The Forum, Cambridge

What is the form?

These joint ventures can take one of two different legal forms: corporate, or contractual

Corporate joint ventures

- The financial and clinical business of the joint venture takes place separately to that of each partner – be they IS or NHS Trust/FT – in a special purpose vehicle.
- This enables the joint venture to plan on a separate strategic level, undisrupted by the business of each of its partners' other activities.
- Can ensure that no single partner takes on more risk than any other.
- Consequently, it provides a more stable basis for partnership than a contractual joint venture, enabling the joint venture to focus on service quality rather than continually having to renegotiate their stake and risk.
- The predominant and most successful legal form of joint venture in the NHS is the limited liability partnership (LLP).
- In an LLP, each partner's liability is limited through the LLP Act 2000.
- It is a corporate body with limited liability, which means that the partners are not automatically liable for the debts of the partnership.
- This is especially favoured if a joint venture involves the participation of the independent sector, as it provides a clear mechanism for the extraction of value and an equal stake in the venture.

Contractual joint ventures

- In a contractual joint venture the parties do not establish any separate entity to carry on the venture.
- Contractual joint ventures are sometimes used by parties to combine resources to bid for the award of a contract or to undertake joint research.
- All the risk in a contractual joint venture is taken on by the host of the operation. This means that they will be responsible for waiting times targets, as well as liable for CQC inspection.
- As no particular documentation or legal structure is required in order for a partnership to exist, it is important that the parties to a contractual joint venture structure their operations so that they cannot be regarded as acting in partnership. If they are treated as acting in partnership they could be subject to unexpected tax and other liabilities. One of the key indicators of a partnership is profit sharing so contractual joint ventures will need to ensure that the arrangements are structured to avoid this.
- A contractual joint venture will not involve the transfer of assets to another entity and so no tax issues should arise on set up or on termination of the arrangements. Also the operation of the joint venture will not involve any sharing of profits so each party will be subject to tax on the profits it makes as a result of the venture.

What is the form?

Reasons to use a joint venture:

- **Business need:** Outcomes are unable to be delivered efficiently and/or effectively when the parties are acting independently.
- **Complementary objectives:** The parties have complementary objectives and skills and each has a contribution to make to deliver outcomes successfully.
- **Shared risks and rewards:** When the NHS body prefers to share the risks of developing and rolling out the JV business (in return for sharing the rewards) rather than bearing them all itself.
- **Corporate entity governance:** The project would benefit from the sort of formalised and well-understood governance system inherent in the creation of a corporate entity. JV structure encourages greater focus on the achievement of a jointly agreed business plan.
- **Separate legal entity:** Desirability for the creation of an entity with its own legal capacity, separate from its founder participants*, so that the JV can: own and deal in assets; enter into contracts in its own right; and, if it is classified to the private sector, work outside some of the specific limitations and constraints of public sector budget control.
- **Access to finance:** an effective medium for raising finance from private sector sources.
- **The ability to retain surplus:** Public sector wishes to have the option to retain surplus in the JV entity to fund service improvement, new technology, or service growth.
- **Access to skills and capital:** Provides access to skills and other resources of partners – any independent sector partner is motivated to make this available as they can benefit from any surplus arising in the JV.
- **Ability to meet quality standards:** Pooling of clinical workforce, rotas, expertise across two or more partner organisations could support each of the organisations to meet the requirements for seven day working.
- **Standardise clinical practice:** Agreed protocols and procedures can improve patient outcomes and drive efficiencies in procurement of medical supplies and devices accordingly.

* Excludes limited partnerships, where contractual relationships are undertaken through the general partner.

What is the form?

Joint ventures are designed to drive both clinical and financial efficiencies and improvements in both

Financial

- Separates the financial activity of the joint venture from the financial activity of the partner trusts.
- This can enable the joint venture to reinvest surplus generated back into the joint venture company.
- This reinvestment can be used to improve clinical standards, or to allow the execution of strategic expansion.
- Joint ventures with the independent sector can provide capital to drive service improvement in a joint venture company.
- FTs already have the power to raise capital on the markets – but this could be a way of NHS Trusts realising the same benefits in certain service areas.

Clinical

- The pooling of clinical resources from a number of different trusts can drive innovation and improvement.
- The creation of a corporate brand associated with excellence and focus on a specialism can incentivise and attract outstanding clinicians.
- Separating elective activity from the business of base trusts can help provide a clinical environments best designed to treat specialist patients – both in the sense of care pathways planning, but also in best use of estates.
- The financial benefit of being able to reinvest surplus into the joint venture company can fund new equipment, good IT systems and the ability to invest in particularly expensive equipment in a strategic way.
- Derive better patient outcomes through the standardisation of clinical practices and increased patient volumes.

What is the form?

A number of pathology joint ventures already have realised some efficiencies

Inputs and Outputs

- A number of different Trusts forming a joint venture means not only the rationalisation of services, but also the rationalisation of back-office. In many cases, it can also entail the more efficient use of buildings.
- Consolidation also often means fewer staff, and thus a reduction in staff costs.
- Higher activity flows are guaranteed, and, consequently, a joint venture company can leverage economies of scale.
- 'In urban areas the scope for consolidation is likely to be greater than in rural areas, where the benefits of scale may be outweighed by the higher costs of consolidation' (Carter Review, 2006).

Hospital Processes

- Pathology joint ventures often involve independent sector partners – such as Serco in Viapath and Integrated Pathology Partnerships in SPS.
- They can bring experience and expertise to the transactions process and improve the ability of the joint venture to execute services efficiently.
- JVs can both increase the number of diagnostic processes, and the quality of service offered – reducing error and money wasted.
- They can also bring proven skills in business transformation and change management, as well as capital for the transformation of services, reducing the time spent in transactions.

Hospital Management

- A special purpose vehicle establishes a separate corporate identity and leadership team for the consolidated pathology services.
- This can enable more focussed management and leadership of the pathology services as the JV activity is separate and distinct from the operation of its founder hospitals, and is as a result less disrupted.
- 'The benefits of scale can be maximised where commissioning networks operate under a single overarching management structure' (Carter Review, 2006).
- 'Enables capacity to be optimised and the workforce to be planned and deployed effectively' (Ibid, 2006).
- Clinical engagement can improve under a separate brand identity, dedicated to the specialism of the clinicians involved.

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Joint ventures

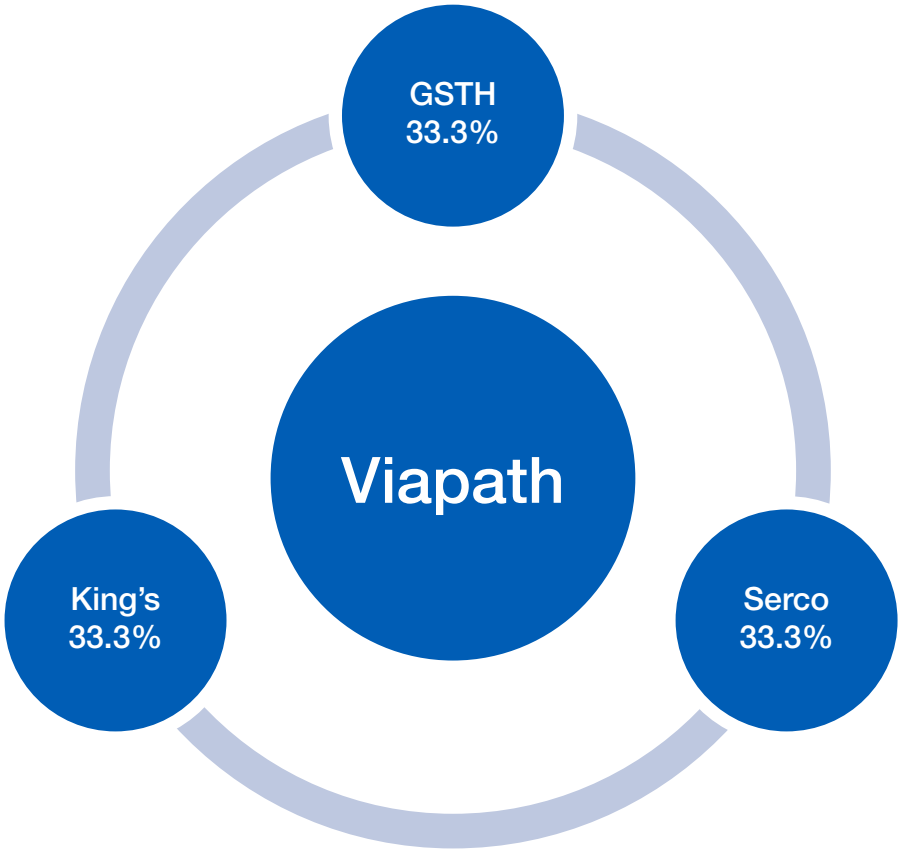
Case study

Viapath have been successful in realising some of these presenting efficiencies

Viapath LLP is a joint venture between Guy's and St. Thomas' NHS FT, King's College Hospital NHS FT and Serco to drive innovation and modernisation in pathology services.

Major Benefits:

- Ability to reinvest surplus in technology and service improvement. There is a direct link between high performance and organisational growth.
- Established an LLP vehicle in which all financials are visible and all in one entity, enabling this investment and return.
- Provides clinicians with a tailored working environment with the latest equipment.
- Has created a corporate pathology brand which is able to pool and attract the very best clinicians.



Considerations:

- Good leadership is crucial in navigating the transactions process.
- It is crucial to have leaders of the joint venture working in the fiduciary interests of the company, as opposed to their shareholders.
- Formed a 'One Organisation' programme in order to ensure that there was no culture clash between partner organisations.
- Proper planning of the transactions process crucial in order to head-off any potential issues further down the line.
- Strategic planning of the activity flows of new institutions is very important.

Case study

There is potential in the NHS for the formation of more joint ventures in elective surgery. Similar efficiencies can also be applied to elective surgery

Inputs and Outputs

- As with pathology joint ventures, back office spending is immediately reduced when consolidated between member organisations.
- Elective surgery joint ventures can also entail a more efficient use of estates. The Elective Orthopaedic Centre (EOC) is based in one building at Epsom hospital, freeing up space previously used for elective surgery at other hospitals.
- Separating elective surgery from trauma surgery in the form of a separate joint venture allows undisrupted activity – and the associated savings that can be made through better pathway and surgery planning.

Hospital Processes

- One of the major improvements the EOC has been able to make is the ability to take control of how long patients stay after surgery – keeping it as low as possible through pathway management and planned pre and post-op care.
- Pooling elective surgery between Trusts also means pooling the clinical expertise of Trusts into an environment dedicated to the pursuit of their specialism. This has the potential to improve care, reduce revision rates, as well as further clinical engagement.
- Improved ability to plan services means an increased ability to turn more overnight stays into day cases.

Hospital Management

- Like pathology joint ventures, the separation of elective surgery and its management means that efficiencies and improvements have the potential to be better planned and better realised.
- Providing a dedicated environment for elective surgery can vastly improve clinical engagement, providing an environment designed specifically to meet the needs of their specialism.
- More activity and good management of that activity with dedicated IT systems fit for purpose can provide much better patient data.
- This data can be used for research and, significantly, procurement, where big savings can be made.

Case study

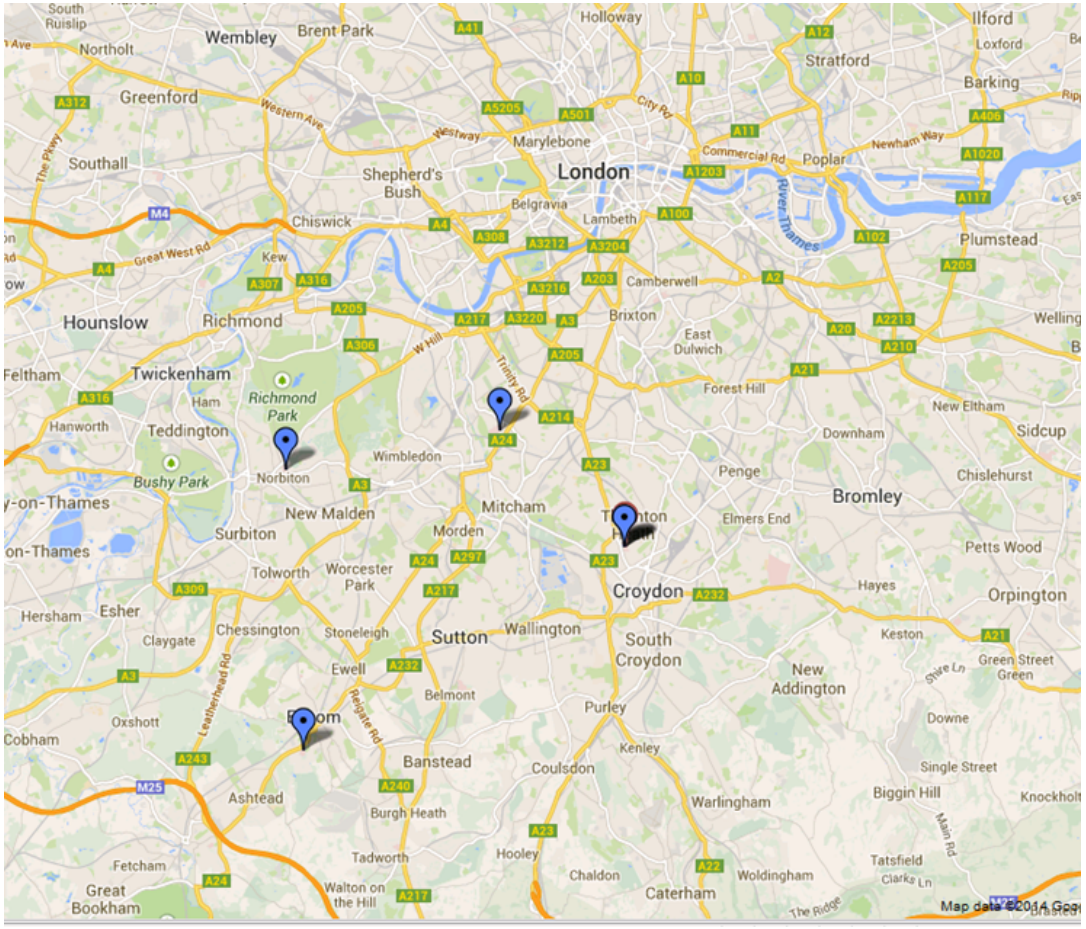
South-West London Elective Orthopaedic Centre has managed to realise some of these efficiencies

What is it?

- A contractual Joint Venture established by four South West London acute Trusts to deliver strategic change in the delivery of planned orthopaedic care:
  - St George's Healthcare NHS Trust
  - Kingston University Hospital NHS Foundation Trust
  - Croydon Healthcare NHS Trust
  - And hosted through Epsom & St Helier University Hospitals NHS Trust
- The EOC has 71 beds (two 27-bed post-operative wards and a 17-bed recovery suite including high dependency and level 3 critical care facilities) and has five orthopaedic operating theatres.

Where is it?

- Epsom hosts the operation on one of its own sites.
- The EOC itself is contained within the Denbies Wing of Epsom hospital, a separate building dedicated specifically to the project.
- A contiguous venture, with each Trust within 40 minutes of the other.



Case study

Some of the outstanding features of the EOC have been enabled by its status as a joint venture, removed from the activity of its member Trusts

Standardised Care Pathways	• *Strong pre-operation consultancy programme so as to be most efficient during surgery and post-surgery.* • *Pathway developed with patients.* • *Post-operative care ward has permanent **intensivist** on duty for rapid assessment of the unwell patient.* • *Nurse and therapy led wards ensure patients are mobilised early, facilitating patient flows.* • *Average length of post-op stay 4 days.*
Procurement Strategy	• *Very clear and effective data collection techniques so as to be in a strong position for both cost-efficiency and innovation.* • *Standardise price, not type of joint procurement. This keeps costs low, whilst still allowing consultants to be innovative.* • *London Procurement Initiative. The EOC runs the prosthetic contract for London, in which 22 out of 28 hospitals save £3 million between them by working together.*

Surplus Generation	• *Financial status in Year One*: Deficit of £4.2 million.
	• *Financial status currently*: £3 million surplus, returning 9-10% margin versus average of 1% for comparable services.
	• *How they achieved it*:
	  • Innovative thinking with maintaining patient flows, such as running their own taxi service to get healthy patients out of beds and back home.
	  • Maintaining high levels of occupancy.

Case study

However, there are some draw-backs to not forming a special purpose vehicle to carry out the activity of the joint venture

Governance	• *Risk not evenly spread across the partners.* It is a contractual joint venture and, as such, Epsom, the host site, runs both the site and all the contracts for the joint venture. It also takes responsibility for any breaches of 18 week RTT, even if the original referral was from another Trust. • *Some confusion over the paths of accountability.* The Director of the EOC reports not only to Epsom's COO, but also to the EOC's own Partnership Board, headed by an independently appointed head.
Financial	• *Lack of reinvestment of surplus in the EOC.* The nature of the joint venture means that most of the surplus is distributed among the four Trusts, and not back into the EOC. • *Have to apply for funds through Epsom & St. Helier* and, as such, cannot take the financial initiative. Stuck in a reinvestment double-bind.
Lack of autonomy	• *Lack of control over consultants' job plans.* This means that the EOC has no ability to change the way in which Trusts release their consultants. • *This has consequent effects on the surgery schedule.* The week can be back-loaded with operations as these tend to be the slots in which consultants are available. • *Would prefer to have 12-14 consultants employed by the centre itself.*

Contents

Joint ventures

Key considerations

This highlights a number of issues an elective joint venture should consider

Geography

- Start-up joint ventures lend themselves to contiguous configuration, drawing on the clinical resources of Trusts in close proximity to each other. These Trusts can provide consistent, high patient flows, sufficient patient numbers to leverage economies of scale, and a concentration of resources, all of which combine to give the joint venture a strong chance of improving care and returning a surplus.
- However, franchising an existing joint venture, which has established its care pathways and ways of working, does not necessarily depend on contiguous partners to succeed and could sit in an isolated rural area, as long as that rural area could deliver large and consistent patient flows.
- As identified by the Carter Review (2006) 'In most parts of the country there are natural networks which reflect patient flows – as in the historic pattern of referrals of people from primary to secondary – core building blocks for reformed services.'

Local Health Economy

- Joint ventures are most effective with high and consistent patient flows so as to realise efficiencies and generate income.
- Consideration needs to be given to the distance between partnering Trusts – it is usually inappropriate to make patients travel substantially for their care.
- Relatedly, a new joint venture is dependent on the contiguity of its partners. This is crucial if the potential benefits of the form are to be realised.
- This is based on the assumption that in an elective joint venture, clinical resources from each of the partners will be outsourced to the joint venture. If the various partners are a considerable distance from each other it will be much more difficult to effectively recruit from member trusts. Nor will integrated pathways be as easily realised.
- The EOC, for example, run their own free taxi service to take patients home, benefiting patients, as well as reducing costs spend unnecessarily in post-care.

Clinical and Financial sustainability of NHS bodies

- A joint venture is potentially applicable to any provider.
- It is very important that all the partners in a joint venture are able to actively benefit from the involvement of all other partners in the venture. Any imbalance could jeopardise the future sustainability of the venture as the primary contributing bodies could feel they are subsidising the others and positive relationships are crucial to the success of any joint venture.
- However, this does not necessarily exclude circumstances in which a high-performer partners with a low performer, because for both the intention will be service improvement. It does mean that there needs to be very careful consideration of this imbalance at the outset – and how the joint venture will seek to address it.

Key considerations

There are no legal restrictions for either Trusts or Foundation Trusts in terms of starting a joint venture or choosing a partner

NHS Foundation Trust/Trusts

- FTs have powers under section 47 of the NHS Act 2006 to do anything which appears to it to be necessary or expedient for the purpose of or in connection with its functions. This includes entering into contracts and acquiring and disposing of property.
- NHS Trusts have identical general powers under Paragraph 14 of Schedule 4 to the NHS Act 2006.
- As such, both NHS Trusts and Foundation Trusts are free to enter into a joint venture, providing that the proposal meets competition requirements.
- There is no specific requirement for Monitor approval where an FT is looking to form a joint venture, unless the joint venture entails the movement of more than 25% of the FT's total activity, at which point the transactions process is triggered.
- Joint ventures between NHS organisations are comparatively rare when compared to the prevalence of the involvement of the private sector.
- Reasons for this are multiple, but the overarching one being that the IS can provide start-up capital, expertise and enterprise to accelerate the venture.

NHS Foundation Trust/Trust with Independent Sector

- Joint ventures of this kind are common and there are no restrictions on whether a Trust/FT can form a joint venture with the independent sector, providing that the joint venture meets all of the established standards, and goes through a requisite procurement process.
- Joint ventures with the independent sector have been favoured for a number of reasons:
  - Independent sector partners can sometimes be more easily provide the start-up capital for a joint venture.
  - They often have an established track record in successful joint ventures, and therefore have the requisite experience to execute negotiations and contracts successfully and quickly.
  - They often have a subject expertise and proven track record in the specialism – for example, The Doctors Laboratory, Sodex and Labco – which can be used to increase the capabilities of existing NHS services.

Key considerations

What is the role of organisational leadership in the form?

This is a collaborative archetype; if purpose and values are not aligned at the start of the joint venture – with all parties working to the same values – it is a venture which will experience great difficulty and will struggle to survive.

The form may well be led by a single high performing organisation, but it is more likely that it will be a partnership of equals. This is because there has to be benefit for both parties at the outset of the venture which can be realised by the partnership,. Each party should be able to receive a benefit from the other party which they would not necessarily be able to realise on their own. If not, there is the risk of future break-up if one party fails to deliver on their contractual obligations.

Visionary leadership is not a necessary condition for joint venture formation, but good leadership is. Effective management of the often difficult to navigate transactions process is crucial if the venture is to be a success, as a number of prospective joint ventures in the NHS have failed before they have even been set up. Excellent management of the new joint venture is essential, however, as often the services including in the joint venture operate with very small margins. Negotiating a new joint venture through an initial period of deficit before surplus is often to be expected.

The success of a new joint venture depends on its leadership team having equal representation on the management board of the venture. There must be clear delineation of ownership and representation from each of the partners on the Partnership Board of the new organisation.

The impact on the Trust Board or on FT governors should be minimal, on the condition that the joint venture contract is one that has been properly thought through and executed. If there are flaws in the joint venture contract then these will play out at a managerial level, potentially leading to disputes and deadlock between the various partners.

Key considerations

Another important consideration in the formation of a joint venture is the approvals process

Many joint ventures alert the interest of the CMA as their formation involves a change in control or ability to influence. However, FTs are able to proceed without approval from Monitor if the joint venture does not involve the disruption of more than 25% of overall turnover. If it does, it triggers Monitor's transactions process, which takes in the region of three months. If there is a clear and strong patient benefit case then this can take precedence over any reduction in competition.

Merger control (2002 Enterprise Act and EC Merger Regulation)	• The formation of a joint venture may constitute a 'relevant merger situation', under the UK's Enterprise Act, if two or more 'enterprises' cease to be distinct.
	• This may occur if two or more partners of the JV allocate part of their assets, business, IP rights, or personnel to the JV.
	• However, CMA will only investigate a JV if it satisfies either of the following tests:
	  • Where the annual value of the UK turnover of two or more of the 'enterprises ceasing to be distinct' exceeds £70m (the turnover test).
	  • Where the JV will supply or acquire at least 25% of all particular goods or services in the UK, or part thereof, and at least two parties to the JV supply or acquire the particular goods or services (the share supply test).

Transferring of Property to a Special Purpose Vehicle	• Any transfer of property from a taxpaying shareholder to the joint venture is likely to give rise to direct tax issues. • If the joint venture is judged to meet HM Treasury's challenge of being 'novel, contentious and repercussive', it will also be subject to HMT scrutiny. • For example, the transfer of a building to JV Co. may result in a capital gains liability for the shareholder, or a balancing charge for capital allowance (tax depreciation) purposes. • If the asset transferred into the JV is UK land, a charge to stamp duty land tax could arise for the joint venture company. • However, depending on the nature of the assets transferred and the tax position of the shareholder making the transfer, exemptions or relief from tax or deferrals of the tax liability may be available.

Key considerations

Engagement with staff is very important if you are to successfully execute the joint venture

Staff Issues: Engagement	• It is very important to involve staff at an early stage, as good engagement is crucial to the success of a new joint venture. • Staff issues (such as the duplication of roles) should be incorporated into the joint venture's affordability form. • There is no legal obligation for a joint venture to offer broadly comparable pension/public sector scheme – it is more a matter of compliance with codes of practice/guidance.
Staff Issues: Transferral of Staff	There are several ways to transfer skills or employees to a joint venture: • Automatic transfer under the TUPE regulations 2006. • The abiding issue with TUPE is in dictating the scope of staff who could claim attachment to work transferring to the JV. • Resignation and re-employment. • Secondment to the joint venture. • Others, such as via a consultancy contract.

Key considerations

Consideration of the exit mechanisms at the outset of the joint venture is very important

- These need to be established during the initial formulation of the joint venture to protect all partners' investments if other participants at some stage wish to exit.
- Exit provisions vary in every joint venture: the due diligence should focus on this and the contract should make clear exactly what the exit mechanism is, whatever the scenario.
- This is likely to be the most difficult issue to resolve; the time it might take to establish these mechanisms should not be underestimated.
- For NHS joint ventures, there should be a much greater emphasis on the need for trigger mechanisms in the contract. These are points at which the joint venture passes a marker-post, either financial or clinical, at which point the partners are contractually obliged to come together and discuss the ongoing direction of the joint venture, and whether exit mechanisms should be enacted.
- Trigger mechanisms seek to avoid situations whereby a joint venture succeeds or fails entirely. If it is heading towards insolvency, it manages this decline so that at no point are services lost to the public. They can be repatriated in time or reconfigured to ensure their continued delivery.
- This is one of the most effective ways of mitigating risk in a joint venture, but especially in an NHS joint venture, where the pressure on the continued solvency of the joint venture – and thus the continued delivery of potentially essential services – is keenly felt.

Examples of Trigger Mechanisms	**Event:** • Material default by one party • Insolvency of a JV Partner • Change of control of a JV Partner • End of licence or end of purpose • Invalid transfer of equity interest

Key considerations

Does the form interact with others, or is it a standalone form?

Joint venture within a federation

Federations provide a fertile environment for the formation of joint ventures within the form. This is especially true if a federation wishes to share service functions between some of its members, as often a joint venture will be required to execute this ambition. Indeed, joint ventures are potentially a useful way of overcoming some of the most significant barriers federations pose, such as the lack of a legal mechanism to execute major change.

Joint venture within a multi-service chain

The case studies examined for the Review have shown that major international multi-service chains make regular use of joint ventures for a number of reasons:

- Partner with key local stakeholders – especially pertinent when moving into new geographical areas.
- Moving into new service areas – the expertise and value added of partners can help a multi-service chain move into new areas, or improve their expertise in an existing one.
- Improving patient flows – Apollo Hospitals Group have a number of joint ventures with the Indian Government, providing them with access to a new market and allowing them to maximise patient flows in their hospitals.

Joint venture being expanded into a service-level chain

- In this situation a successful joint venture would become the hub site in a service-level chain, with spokes in new, non-contiguous organisations using the same systems, processes and expertise as the hub.
- The most ambitious option – with regard to joint ventures interacting with other forms – but the option with the largest potential for realising clinical and financial benefits.
- This is because a service-level chain of, for example, elective orthopaedic centres, would overcome some of the major obstacles to the formation of joint ventures, such as the need for a cluster of local trusts and the uncertainty entailed in the establishment of a new joint venture.

Key considerations

Which primary motivations does this form work best for?

Defensive	• Defensive motivations are largely those which are protective and seek to guard existing services. Such motivations are rarer in joint venture structures because of the ways in which the most joint ventures look to improve services, or capitalise on opportunities. • The primary defensive motivation is that of risk sharing. If a number of trusts take control of a set of services, there is a broader chain of accountability, and greater resource input, meaning that those Trusts in difficulty can share their risk with those who may not be in such a situation. • Whether a joint venture is defensively motivated or not can also be defined by the type of joint venture entered into. For example, a joint venture set-up with a property management company for the rationalisation of estates is a temporary joint venture, with a clear objective to realise the value of that estate. • A trust could be looking to establish a joint venture to protect a specialism which they otherwise think will be unsustainable, or will fail. Forming a joint venture could provide a way to continue to deliver this service to patients.
Strategic	• Pool best practice and combine patient flows from a number of different bodies in order to make specialist services return a surplus. • Take advantage of the intellectual property or skills of a neighbour in order to improve your own services. • In a partnership with the IS, use their capital generation ability to enable the rejuvenation of services in the form of a joint venture – which could include new buildings or employees. • Improve patient outcomes – there is evidence which suggests that the combination of high patient flows, good associated data, and streamlined care pathways – all enabled by joint ventures – can combine to improve services from the level at which they operated in a base trust. • Financial efficiencies – whilst the overarching motivation for a joint venture will rarely be financial, good data collection does mean that big savings can be made on procurement, if done well. Savings can also be made from removing duplication of services. • Quality standards – ensuring that all organisations can continue to meet the requisite quality standards over seven days.

Key considerations

Are the barriers to the form primarily technical, strategic, or both?

Technical	• Uncertainty over the requirements of procurement: this is both when it is required and what laws regulate its use. • Not many NHS managers and leaders have had experience of managing significant transactions which has meant that there is a lack of clarity of the 'rules' and processes associated with an undertaking of this nature. • Tax issues in the creation of special purpose vehicles – especially with regard to stamp duty when property is transferred to the vehicle – are little known and can slow formation of the ventures. • Commercial and business acumen is becoming increasingly sought after in the NHS as many organisations start to develop commercial and enterprise strategies. This skill set is not yet commonplace as many leaders and managers have had an operational grounding.
Strategic	• Confronting the managerial/leadership challenge of forming a joint venture. • CMA issues over mergers and whether the joint venture captures too much of the activity in a geographic area. Especially true if this pertains to the consolidation of a specialism. • A lack of knowledge about the true nature of CMA and Monitor attitude to the effect of competition on the provision of services. The test will always be its effect on patients, if there is a strong patient benefit case, competition requirements can be overcome. • Worry about the effect a joint venture would have on CQC inspections and uncertainty about who would take on the inspection risk. • The lack of commercial exposure at a senior level has meant that many organisations are only recently starting to consider the development of organisational forms such as joint ventures but need further advice and guidance.

Key considerations

Does the form pass the three sense checks?

Does it make sense in the context described?	• There are already a number successful joint ventures in existence in the English NHS, both NHS to NHS and also NHS or social enterprises with the independent sector. • A lack of clarity regarding the establishment of special purpose vehicles and the different contractual mechanisms has meant that the organisational form is not as wide spread as potentially it could be.
Will it make a difference?	• In order to meet quality standards over seven days, organisations are going to have to establish how they are going to recruit and retain the requisite numbers of staff. Joint ventures enable organisations to pool their workforce in order to ensure that the standards can continue to be met through shared resources. • Joint ventures may also offer organisations an opportunity to make greater financial savings on back office and support services than may be available to the individual organisations.
Is it feasible?	• It is feasible to establish a joint venture both NHS to NHS and also NHS with the independent, voluntary or social enterprise sector. • The organisations entering into the partnership need to be clear about the governance, accountability and any risk or gain share that will be made through the joint venture. • Understanding how the staff will be employed and any employment law considerations such as TUPE should be considered up front.

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