Department of Health

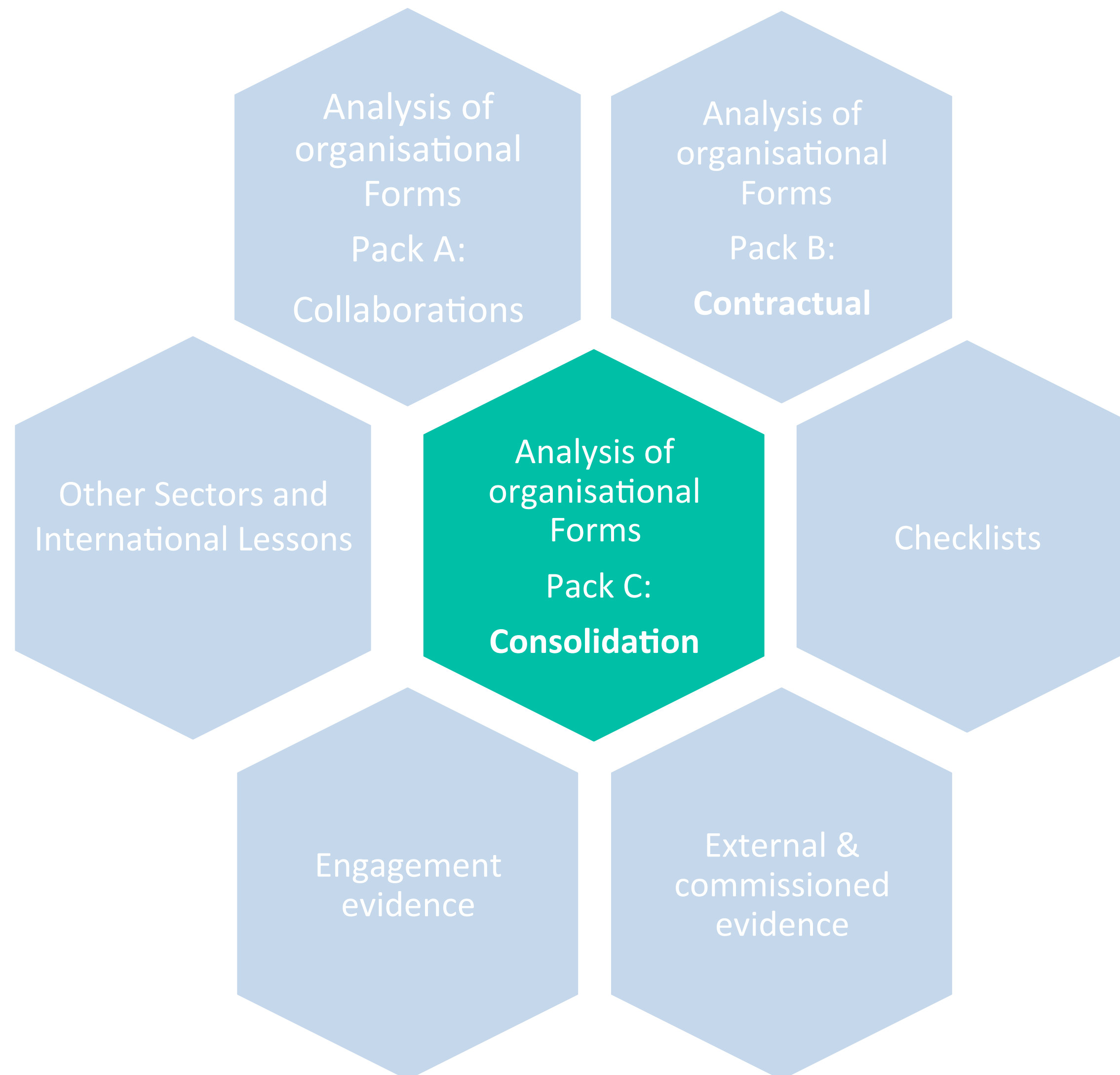
# Dalton Review: Examining new options and opportunities for providers of NHS care

## Pack C: Consolidation 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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## Overview

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# Overview

## 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

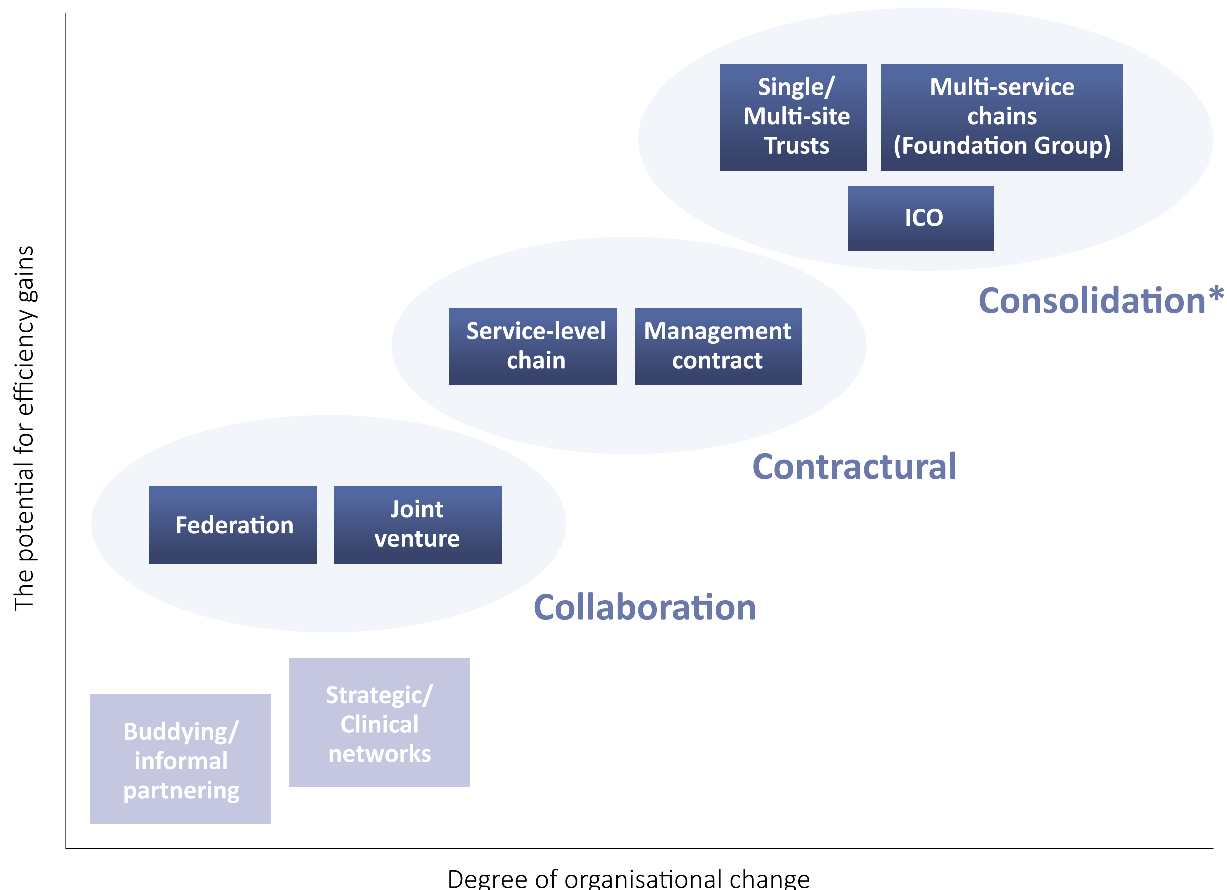
- Variations in performance among providers are wide and persistent, with some organisations having a long history of financial and clinical challenges.
- In a context in which there are increasing concerns about the quality of care providers deliver, looking for ways to organise and deliver services 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 models 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.

# Rationale

## 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

# Rationale

## 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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# Literature review

## Merged horizontal organisations have the potential to drive through efficiency gains through integration but the evidence is mixed

**Hospital consolidation is expected to lead to greater market influence, economies of scale and scope, reduce duplication of resources and improved efficiency in the provision of services. However, the evidence is mixed.**

### Single and Multi-site hospitals

- Single- and multisite hospitals are the most common organisational form in the NHS. Usually formed through mergers and acquisitions.
- Trust merger has historically been the default option in NHS for addressing financial failure.
- Mergers in healthcare are expected to bring economic, clinical and political gains. Economic gains are expected to from economies of scale and scope, particularly through reductions in management costs and the capacity to rationalise provision (Kings Fund, 2014)
- However, there is a lack of conclusive evidence on the impact of mergers.

### Multi-service hospital chains*

- Hospital chains are single entities that own and operate multiple stand alone hospitals under the leadership of a single Board of Directors. They use standardised operating practices and shared back office functions to achieve consistency of service quality across multiple sites.
- Hospital chains may lead to quality improvements as increased size allows for more costly investments and the spreading of investment risk.
- Also there is evidence that a higher volume of certain services is associated with better quality of care.
- However, the evidence between size and efficiency is not clear-cut.

* The Review refers to these as Foundation Groups for the purposes of NHS bodies

# Literature review

## Hospital consolidation should have clear, quantifiable objectives and a road map as to how these will be achieved to be successful.

### Single & Multi-site Trusts

- **Drivers for mergers in healthcare are the expected economic, clinical and political gains.** But evidence suggests that scale economies are exhausted in the 100-200 bed range, and that clinical outcomes improve in some specialities due to higher volume but these too are exhausted at relatively low thresholds. (Fulop et al 2005:220)
- **Context is important in mergers.** Over-simplified assumptions about the potential benefits of mergers often fail to reflect complex, dynamic relationships and organisational cultures. In public sector mergers are easily politicised due to involvement of multiple stakeholders. Conflicting public sector objectives make the merger process more complex and can delay the service developments. (Fulop et al, 2005)
- **Mergers may not progress as according to plan.** Unexpected consequences including managers being more remote, a loss of autonomy and responsiveness, problems integrating staff, services and systems, a clash of cultures, and prevailing problems in the local health economy were all found to limit the effectiveness of mergers. For example, perceptions that a Trust was being "taken-over" can limit the sharing of good practice. (Fulop et al, 2005; Fulop et al, 2012)
- **There is limited evidence of mergers and acquisitions delivering significant benefits in financial or clinical performance.** This likely due to absence of substantial changes in service delivery, partly due to lack of proper integration of the merged organisations (Dash, 2013)

### Multi-service chains

- **The evidence of the effects of hospital consolidation is not clear-cut.** Hospital consolidation may lead to quality improvements. Increased size allows for more costly investments and the spreading of investment risk (RAND, 2014).
- **Context within which the hospital groups operate in matters.** Hospital groups or systems that are managed by a single legal entity may be more successful in achieving efficiency gains and improvements in the quality of care than hospital networks that are formed through strategic alliance or contract agreement but this is likely to depend on the context within which they operate (RAND, 2014).
- **The required management style and leadership skills in hospitals groups are different from other, more traditional organisational forms.** A management system with a corporate centre and outposts, rather than appending an acquired institution to the existing system is needed. This requires a management approach that has a distinction between central and outpost tasks and responsibilities, as well a focus on standardisation. (Nuffield Trust, 2014)
- **Better performance metrics**; Where effective strategies for hospital care improvement exist (standardisation, quality measurement), corporate centre can initiate improvements in outposts (Nimptsch and Mansky, 2013)
- **Higher volume benefits**: Hub-and-spoke architecture and using spokes as gateways to hub, helps in creating large volumes. This improves quality through building talent, incentives for developing and updating treatment protocols, specialisation of clinicians and promoting innovation suited to local conditions. Additionally sharing comparative performance data across hospital group sites encourages clinicians to share best practices (Govindarajan and Ramamurti, 2013).

# Literature review

## Vertical integrated organisations can enable organisations to coordinate health care services more effectively

Integrated care may allow organisations to collaborate, often on a long-term basis, to mutual benefit and deliver coordinated health care.

### Integrated care organisations

- Integrated care organisation is a formal or virtual vertically integrated organisation from primary to acute service levels, often serving a defined population. It provides a full range of services, and shares some assets.
- A distinction can be drawn between real integration, in which organisations merge their service, and virtual integration, in which providers work together through networks and alliances.
- Integrated care can take many different forms. The most complex forms of integrated care bring together responsibility for commissioning and provision.
- There is good evidence of the benefits of integrated care for whole populations, as seen in organisations such as Kaiser Permanente, the Veterans Health Administration and integrated medical groups in the US (Kings Fund, 2011).
- Theoretical rationale for vertical integration suggests improved coordination among partners (e.g. lower costs in monitoring and contracting) exceeding forgone gains from specialisation. (Burns and Pauly, 2002)
- Integration may not adequately change patient care delivery, it may increase financial outlay in setting up integrated approach, and there may be a lack of managerial experience in leading an integrated care network.
- Managing competing interests within integrated care network can be difficult, and patients may have preferred clinicians/organisations outside the integrated network. (Burns and Pauly, 2002)
- Evidence indicates that organisational integration will not deliver benefits if clinicians do not change the way they work (Kings Fund, 2011).
- Studies have shown that the shift to integrated service networks resulted in a 55 per cent reduction in bed day use and improvements in quality of care (Kings Fund, 2011).

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## Overview


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# Summary of collaboration forms

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

The logos above represent many of the organisations visited or considered by the Dalton Review team. This does not indicate endorsement by the Dalton Review.

# Summary of collaboration forms

## 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)** |

# Summary of collaboration forms

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

| Form | Potential 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.** |

# Summary of collaboration forms

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

| Form | Potential 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 JVs 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.** |

# Summary of collaboration forms

## 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.** |

# Summary of collaboration forms

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

<table>
<tr><th>Archetype</th><th>Competition Considerations</th></tr>
<tr><td>Federation</td><td rowspan="6">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.<br><br>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.<br><br>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.</td></tr>
<tr><td>Joint venture</td></tr>
<tr><td>Service-line contract</td></tr>
<tr><td>Management contract</td></tr>
<tr><td>Multi-site Trust</td></tr>
<tr><td>Multi-site chain (Foundation Group)</td></tr>
<tr><td>Integrated Care Organisation (ICO)</td><td>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.</td></tr>
</table>

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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## Single and multi-site Trusts


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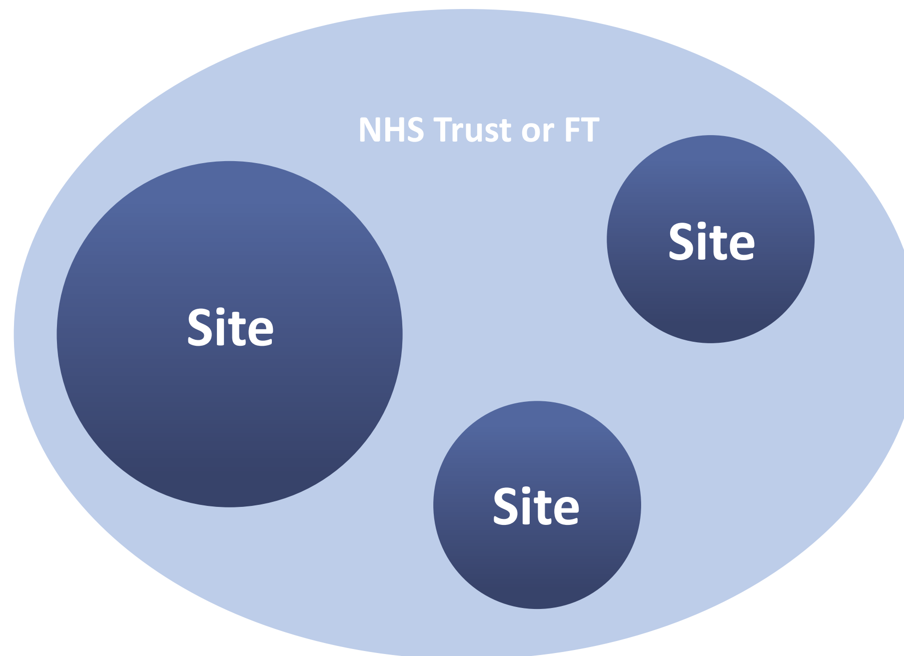
# What is the form?

## Single and multi-site Trusts are single entities that own and operate one or more sites under the leadership of a single Board of Directors



# What is the form?

## Single and multi-site Trusts are the dominant form in the English NHS – They may have remained as established or formed through mergers or acquisitions

| Organisational sovereignty | Assets | Intangibles | Range of services | Scale |
|---|---|---|---|---|
| Single organisation. | Some sharing across sites. | Single system. | Usually full range. | Single geography – local scale. |

**Key features:**

- Most prevalent option in English NHS – the status quo.
- Single organisation operating over one or more sites, serving defined population within single locality.
- Allows for rationalisation of service provision between sites.
- Limited autonomy of operations within sites – single executive team.
- Range in size from small District General Hospitals (DGH) to large multi-site Foundation Trusts (FT).
- Organisation expands through both organic growth and strategic decision-making, and/or a combination of both.
- Local need, desire to expand geographical reach, willingness to take over a failing Trust can all motivate expansion towards a multisite Trust.

# What is the form?

## Multisite working offers some advantages over single site Trusts, but can also add complications

### Single and multisite Trusts

- Single organisation operating services on single or multiple sites.
- Contiguous – clustered in single local geography.
- Centralised leadership, single executive team provides strategic and operational leadership across site(s).
- Proximate site servicing geographically contiguous population, so strong potential to rationalise clinical services and activities.
- Some potential to drive standardisation of best practice via internal benchmarking due to strong potential for rationalisation and less duplication of services.
- Possible economies of scale through service rationalisation and unified support functions.
- Possible diseconomies of scope from complexity of providing large number of specialties.
- The merged organisation can continue to have cultural differences on each site for years post-merger if the culture was not addressed as part of the original merger.

### Why move from single to multisite

**Advantages**

- Staff can be moved between sites to meet demand / ensure 24/7 working. But distance matters — >30min drive makes it more difficult; and only possible in certain specialities e.g. not in A&E.
- Possibility for more training and career development opportunities due to staff rotation.
- As a larger organisation it can be easier to build reputation, attract top talent and develop chosen specialities.

**Disadvantages**

- Sites if geographically distant / difficult to access may reduce staff training and rotation opportunities.
- Patient confusion (which site to go to).
- Management of distant sites may be difficult – need strong operational leaders on-site.
- Moving from single to multisite a huge challenge (managerial, cultural, operational).
- Culture may prevail causing disharmony and challenges to moving staff across sites

# What is the form?

## There are several possible configurations to manage multisite working, but strong Clinical Directors and Hospital Directors are important

- **The formal governance arrangements of single and multisite Trusts are the same. Both are led by a Trust Board, which is collectively responsible for the strategic direction, operational management and performance standards of the Trust, including any sites it may have.**
- **Where the Trust has more than one site, there may be different configurations of the local management teams. One approach is for the separate sites have senior managers that are responsible for the day to day operation of the site and who support the Clinical Directors / Directors of Care / Clinical Heads of Division responsible for individual key areas. To manage the challenges of distant sites, managerial expertise must be strong.**

| | |
|---|---|
| **Trust Board** | **A Board of Directors for the multisite Trust:**<br>• Board of Directors comprising Chair, Non-Executive Directors, Chief Executive, Medical Director, Nursing Director, Finance Director, etc.<br>• Responsible for setting the strategic direction for the Trust, the operational management of the Trust and managing its governance and performance targets. |
| **Separate sites** | **One approach is to have dedicated senior managers for each individual site that support the Clinical Directors / Directors of Care / Clinical Heads of Division:**<br>• Dedicated senior managers are responsible for operational leadership of the site within the strategic, quality and financial frameworks set by the Trust Board — responsible for the day to day operations on the site.<br>• Typically operate under the management of the Chief Operational Officer, who sits on the Trust Board.<br>• Clinical Directors / Directors of Care / Clinical Heads of Division in certain key areas at each site (some services may have one overall General Manager for all sites) responsible for clinical standards at the site. Details dependant on Trust size and other arrangements. |

# What is the form?

## Three ways to move from single to multi-site – merger, acquisition and new development

### Mergers

#### Definition

Two Trusts, often of broadly the same size and performance, agree to form a new single Trust. Boards often merged / CEO of another Trust joins the Board.

#### Why merge

- Strategic choice to gain a new site.
- Synergy: staff reduction, clinical pathways, economies of scale, acquiring/ strengthening specialisms, improving service offerings, improved market reach and visibility.

#### Disadvantages

- Senior management time diverted.
- Culture clashes between Trusts.

#### Past examples in NHS

- Epsom and St Helier.
- Barts Health.

### Acquisitions

#### Definition

One Trust takes over the other, and clearly establishes itself as the new owner. The board from acquired Trust dissolved / removed. Often larger/high-performance taking over small/challenged Trust.

#### Why acquisition

- Strategic choice to gain a new site.
- Same potential synergies as from merger.

#### Disadvantages

- Same as mergers.

#### Past examples in NHS

- Royal Free / BCF 2014.
- Central Manchester / Trafford 2012.

### New build

#### Definition

Building a new site to establish multi-site working. Can be done by the Trust or under e.g. private finance initiative.

#### Why new build

- Strategic choice to gain a new site.
- Expand services to new markets, if existing space limited or patient flows markedly increase.
- Correcting market failure.

#### Disadvantages

- Expensive (time and money).
- Complex.
- Risky.
- May already be existing hospital that has captured the market.

#### Past examples in NHS

Trusts often expand the size of their single-site Trust, but there are no recent examples of new sites being built for multi-site working.

# What is the form?

## Past M&A deals have delivered mixed results, but acquisitions of challenged organisation by high-performing Trusts might be more successful

- **The distinction between a merger and an acquisition is blurred.** Sometimes acquisitions are "sold" as mergers to get more buy-in from the acquired Trust Board and staff.
- **Analysis suggests that mergers in the NHS have been largely unsuccessful in the past.** Comprehensive evidence base that suggests that past mergers have not led to forecast cost savings or quality improvements. Some mergers were successful in reducing capacity in less concentrated markets.
- **There are various reasons that may have stopped mergers delivering projected benefits.** Over simplistic assumptions, unexpected consequences, a lack of significant post-merger change are just a few of the reasons for ineffective mergers.
- **There is a suggestion that acquisitions by high-performing FTs of struggling Trusts, could be more successful – though more evidence is needed.** It is argued that a primary reason that past NHS mergers have failed is because they tended to be mergers of equals (usually of two poorly performing Trusts). Theoretical arguments suggest that "takeovers" (by successful Trusts of challenged ones) *could* be more effective in delivering improvements.

### Common drivers

- Financial unsustainability (and more recently a consequent inability to attain FT status). Often involve combining with a nearby high performing or more financially viable organisation.
- Response to workforce pressures: e.g. inability to recruit, offer appropriate training opportunities, and comply with the EU working time directive.
- Often regional commissioning oversight or regulatory intervention driving changes.
- The autonomous nature of FTs (and removal of Strategic Health Authorities) means that future merger activity may be driven by organisations themselves. This means that "takeovers" may be driven by market conditions more similar to those that drive merger activity in the private sector.

### Unexpected consequences of NHS M&A limit effectiveness

- Managers being more remote, a loss of autonomy and responsiveness, problems integrating staff, services and systems, a clash of cultures and prevailing problems in the local health economy.
- Perceptions that a Trust was being "taken-over" can limit the sharing of good practice.

### Other potential reasons for failure

- Expense.
- Economies of scale may have already been realised in many cases; hospitals in England are already large by international standards.
- The proposed synergies between the hospitals may be not realisable.

# What is the form?

## There are 5 key Trust-level conditions for a successful M&A process – clinician support, staff engagement, public acceptance, adequate resources and consistency of approach

- **Senior NHS managers involved with large scale provider changes (reconfigurations, mergers and acquisitions) have identified five key issues necessary for successful outcomes – clinician support, staff engagement, public acceptance, adequate resources and consistency in approach.**
- **Academic literature and conversations with senior leaders from other sectors point to the same key issues as well.**

| Issue | What is needed? | How it helps? | Impact on change? |
|---|---|---|---|
| Clinician support | A robust, clinically based case for change and using local clinicians to make the case for change to the public. | Helps secure staff buy-in and public acceptance. | Sharing best practices may be limited if there is no clinician support for change. |
| Clinician support | Building staff support for changes (especially at consultant and nurse level). | Successful change relies on staff changing their behaviour, either through working across sites, in different rota patterns or as part of a new organisation. | Sharing best practices may be limited if there is no clinician support for change. |
| Public acceptance | Building staff support for changes (especially at consultant and nurse level). | The importance of engagement is widely accepted, but some areas found it impossible to persuade the public or local politicians of the need for change. | Opposition can impact on the time taken to achieve change. Trusts may also avoid service changes or soften approach to meet local opposition. |
| Adequate resources | Trust level dedicated resource to support the change. | The importance of engagement is widely accepted, but some areas found it impossible to persuade the public or local politicians of the need for change. | Lack of clarity about the exact drivers of deficits can hinder attempts to address them. Where change follows previous attempts to address failure, clear data about the financial health of the organisation may be limited. |
| Consistency in approach | Clarity of purpose, objectives and having consistent communications messaging | The complexity of very large mergers, alongside multiple and sometimes distant sites, was highlighted as a significant problem. | Literature on mergers highlights failures to assess potential drawbacks of change. This can lead to unintended consequences such as slower decision-making; increased travel times; and problems in integrating staff, systems and working practices. |

# What is the form?

## Mergers and acquisitions – key questions for due diligence concentrate around general motives, finance, clinical services and service and estate reconfiguration potential

| | |
|---|---|
| **General** | • Objectives for the transaction?<br>• Any unknown issues that could affect the enlarged organisation?<br>• Logistical issues?<br>• How compatible are the two organisations (culture, geography, leadership, finance etc.)? |
| **Finance** | • Historic information, e.g. audited accounts and other detailed financial information.<br>• Forecast information, e.g. forecast income and expenditure, balance sheets, cash flow and working capital.<br>• Sensitivity analysis – how will the transaction impact and influence future financial risks and opportunities. |
| **Clinical** | • Different service offerings in the two organisations – do they complement or conflict?<br>• Potential for economies of scale or service improvement arising from the M&A?<br>• Need for any reconfiguration of services? |
| **Service / Estate Reconfiguration** | • Number of sites and can they be combined into one or fewer sites? Or re-serviced?<br>• Is the service reconfiguration and locations of new sites a positive move in terms of the local community?<br>• Does location of other health services or specialities of the Trusts affect the M&A plans?<br>• After reconfiguration, can old sites be sold (for cash flow to fund deficits / future capital projects)? |

## Case studies for the multi-site Trust form

# Case study

## There are several ways of achieving the benefits from co-operation without merging / being acquired

Co-operative arrangements that can bring benefits without merging can include organisational forms such as buddying, federations, partnering and the sharing of managerial resource.

### Buddying

- 2013 SofS directed initiative – "good" hospitals should be linked with and rewarded for supporting "failing" hospitals
- Senior leadership of a successful hospital support leaders in failing hospital to make necessary changes

### Motivation to buddy?

- Good hospitals: Altruistic, learning from bad practice, financial rewards (potentially in the future), development of staff
- Failing hospitals: Learning from best practice, staff secondments, senior executive support
- Both: Sharing best practice, develop leadership skills, joint development of back office and staffing solutions, better understanding of local conditions

### What to be aware of?

- Diversion of senior management time
- Structural difficulties in failing hospitals may be impossible to correct
- Just leadership support is not always enough (deep financial, operational, structural issues)
- In practice can be difficult to implement
- Decision-making – no delegated decision making rights and so therefore difficult to influence without a strong relationship

### Emerging findings:

- Diverse approach to buddying across NHS – several different types of arrangements from one-to-one to networks
- The buddy needs to understand local challenges and cost drivers
- Informal support relationships likely to emerge after expiry of formal buddying arrangements

# Case study

## A form of co-operative arrangement – Management sharing at WMAS and EEAS

### Background

East of England Ambulance Service (EEAS) is struggling and needed an experienced CEO to take the helm. The West Midlands Ambulance Service (WMAS) CEO was recruited in January 2014 to run both services concurrently.

**What drove change:**

- EEAS: Dysfunctional service, demotivated workforce, inadequate workforce plan, difficult to recruit to.
- Support challenged organisation, spread best practice and improve patient care.
- Potential advantages for WMAS through development opportunities for senior staff and financial gains being used to benefit patients.

**To be aware of in similar arrangements:**

- Need a formal signed agreement on sharing CEO time, the time pressures may be considerable.
- Formalising senior buddy appointments may be helpful.
- Thorough due diligence process on time demands and risk to the buddy organisation (cost, reputation, diversion of senior management time) needed.
- Potential cost implications, pay revisions, public scrutiny and expenses need to be considered, particularly where geographical distances great.

### Action taken and challenges

**What is being done:**

- Staff engagement considered to be key factor to focus on – contact with senior management encouraged (including CEO), CEO meeting staff personally, work with staffside representatives; These initiatives have been seen to improve staff ‘buy in’ for change.
- WMAS culture focused on patients and efficiency, attempt to bring this into EEAS through staff training and support for individual staff.
- Formal buddying arrangements put in place to strengthen managerial and individual level in front-line, operational and corporate functions.
- Managerial reduction program to decrease excessive levels of administrative and management staff in EEAS freeing up resources for the frontline.
- Root and branch review of budgets to find cost-savings such as reduction in the use of external consultants and focusing on the key priorities.

**Challenges:**

- Inspiring people to change, getting traction to implement new ways of working.
- Some EEAS managers resistant to change – this has been handled through voluntary and compulsory redundancies, and through moving people to different jobs better matched with their skills.
- Diversion of senior management (e.g. CEO) time.

# Case study

## A recent example of an acquisition: Royal Free London NHS Foundation Trust / acquisition of Barnet and Chase Farm Hospitals 2014 (from 1 to 3 sites)

### Background

Royal Free London NHS Foundation Trust (RF) acquired Barnet and Chase Farm Hospitals (BCF) from 1 July 2014, moving from a single site Trust to a multisite Trust (from 1 to 3 sites).

In July 2012, the Barnet and Chase Farm Hospitals Board determined that it was unsustainable in the long term and subsequently made the decision it needed to be acquired.

Several nearby Trusts initially expressed an interest as merger partners, but the Royal Free was the only Trust to maintain an interest and was subsequently identified by Barnet and Chase Farm Hospitals as the best option to pursue further. In the end, RF was the only Trust with a final submission.

As the acquisition is so recent, it is difficult to predict how successful it will be, however the RF leadership team have put in a significant amount of groundwork over the two years including seconding their own staff into key Board positions. This may result in greater benefits realisation.

There are efficiency savings and economies of scope to be gained through the acquisition and further reconfiguration of services, and a broad support from clinical leaders is beneficial. At the same time there are deep cultural differences between the hospitals, and a lack of clinical and mid-managerial leadership skills in BCF which will need to be imported from RF or otherwise trained on-site.

### In brief

#### What drove change

- Financial issues at BCF – not able to achieve FT status on its own, and regulator pressure towards being merged with another Trust.
- RF strategy – to be a major acute provider in North London and Hertfordshire; BCF offered RF a chance to acquire critical mass in some general/non-specialist services (e.g. paediatrics, colorectal).
- RF strategy – system leadership in integrated care; acquiring BCF could improve clinical pathways and care integration.
- Defensive – if not RF, another Trust would take over BCF.

#### Drivers of success

- Ability to reconfigure services for efficiency savings and gain economies of scale.
- Support for acquisition from clinical leaders and CCGs.
- RF had their own senor staff seconded onto the Trust Board pre-acquisition and post acquisition the BCF Trust Board was wholly replaced so no issues with integrating senior leaders into RF.
- The planned Barnet, Enfield and Haringey Clinical Strategy reconfiguration was already completed – downgrading the Chase Farm site.

#### Barriers to success

- Cultural differences between RF and BCF – RF a big teaching hospital, BCF more like a DGH.
- Lack of leadership capability in clinical and mid-managerial staff in BCF.

# Case study

## Mergers and acquisitions are a common choice in NHS – three examples

### Central Manchester University Hospitals NHS FT / acquisition of Trafford Healthcare NHS Trust 2012 (from 2 to 5 sites)

Central Manchester University Hospitals NHS Foundation Trust (CMFT) runs eight hospitals over five sites in Manchester and Trafford and provides a range of community services in Manchester area. The Trust treats >1m patients annually.

CMFT acquired Trafford Healthcare NHS Trust in 1st April 2012. At the time CMFT had two sites and five hospitals, and after the acquisition it had five sites with eight hospitals.

The acquisition enabled some immediate savings due to reduced duplication, and later instigating long term service change. Some Trafford services were reconfigured, with improved patient outcomes and experiences. The acquisition resulted in clinical improvements and financial savings, and is viewed as a particularly successful NHS acquisition.

CMFT has started to operate in a Group structure with each Division an accountable site such as MRI or Trafford

### Epsom and St Helier / Merger 1999

Epsom and St Helier hospitals merged in 1999 and the financial position has shown a number of fluctuations in the following 15 years. Epsom was a small Trust that had struggled financially for several years and the merger met the primary objective of keeping the Epsom Hospital Trust financially viable.

By 2010, the Trust was considering plans for a de-merger, following assessment that it could not achieve FT status by 2014 in current form. However plans for a de-merger and talks with other partner hospitals has ceased in 2012 and the Trust is in discussions with the TDA about its future in the Foundation Trust pipeline.

The Trust could be described as a success, given the current configuration of services is deemed safe and the Trust has potential to enter the FT pipeline, but there are also additional nuances to take into account.

### Barts Health NHS Trust / Merger 2012 between Barts & The London, Whipps Cross, and Newham University Trusts

The Trust was established in 2012 as a result of a merger between Barts & the London, Newham University and Whipps Cross Trusts. The perception was that Whipps Cross and Newham were in significant financial difficulties, but Barts was a stronger hospital. NHS London (Strategic Health Authority) strongly encouraged the merger and supported implementation.

Other factors driving the change were the local demographics, with large and growing population, and the chance to enter the FT pipeline.

The merger has improved some patient outcomes, reduced deficits, and some clinical benefits have achieved, such as streamlining outpatient pathways. However, not all the benefits have been realised and Barts has experienced significant financial problems and some of the contracting arrangements with commissioners are complex.

# Key considerations

## What are the scenarios in which the form could apply?

**Single and multisite Trusts can exist in nearly any setting, and successful Trusts taking over challenged Trusts can increase financial and clinical sustainability in the wider NHS.**

| | |
|---|---|
| Geographical factors | • The form can apply to all geographical circumstances, ranging from being situated in cities to remote locations.<br>• However, as larger care centres become the preferred option, it is likely that single and multisite Trusts will become concentrated in cities and towns that serve large catchment areas.<br>• Single and multisite Trusts serve a geographically contiguous population. While some of the sites of multisite Trusts may be relatively distant, they still remain in the same local health economy. |
| Financial and clinical sustainability | • Single and multisite Trusts can be used to improve the clinical and financial sustainability of Trusts through reconfiguring services, assets, estates and administration and back office.<br>• When a successful Trust takes over a poorly performing Trust the use of best practice, and reconfiguration, can deliver considerable clinical improvements and financial savings.<br>• Deeply challenged Trusts are unlikely to be desirable to acquiring organisations.<br>• Theoretical work suggests that acquisitions are likely to end up in better outcomes as mergers have to accommodate too many factions within the Trust. |
| Services offered | • Single and multisite Trusts are typically multiservice Trusts.<br>• In principle it is possible to have a specialist Trust, such as Moorfields Eye Hospital. |
| Interactions with other archetypes | • Single and multisite Trusts can interact with all other archetypes.<br>• They are likely to be the foundation blocks for all the other archetypes. |

# Key considerations

## Does the form apply across some or all geographical circumstances?

**Single and multisite Trusts can operate nearly anywhere, as long as the locations are geographically contiguous.**

### Cities, towns, rural, remote

In principle single and multisite Trusts can appear in all different geographical locations, ranging from large metropolitan cities (which would have several single and multisite Trusts to service the population) to remote locations.

However, there has been a shift towards reconfiguration of services and concentration of care into larger centres. For hospitals with emergency services consolidated on one site, the Royal College of Surgeons of England recommends a minimum hospital catchment area of 300,000 people; this would require a significant reduction in the number of A&Es in England. This may lead to single and multisite Trusts to be more common in cities and towns, as smaller local rural and remote hospitals will be decommissioned.

### Single and multisite Trusts work in a geographical contiguity

Single and multisite Trusts serve a defined population with a single locality, meaning they are geographically contiguous. There may be some distance between the sites, but they serve geographically contiguous populations. Non-contiguous sites would most likely require separate leadership structures, facilitating the move towards a multiservice chain.

# Key considerations

## Does the form apply across different health economies?

**Single and multisite Trusts need sustainable patient flows, and entrants and exists in neighbouring locations can affect the flows and viability of the Trust.**

### Is the form dependent on high activity capture?

Single and multisite Trusts need a strong enough patient flows to remain sustainable, and need to be relevant to patient needs and local health economy in order to capture them.

### Is the form dependent on close neighbours to join with?

If the Trust is planning to expand through M&A, the geographical area should have relatively close neighbours that can be taken over. If a new site is purpose-built, existence of close neighbours may make it difficult to capture enough of patients flows to make the new site sustainable.

### Is the form dependent on predictable activity flows?

Sustainability of single and multisite Trusts needs predictable activity flows.

### If the provider landscape changes, will the form still be viable? i.e. would neighbouring entrants or exits lead to unsustainability.

Neighbouring entrants might capture patient flows making the form unsustainable. Exits from the market would most likely mean patient flows were directed towards the existing hospital(s). If these hospitals are capable of managing the increased patient flow the form remains viable, but if capacity is limited, expansion into new sites may be required.

### Does the form apply to both NHS and IS providers?

Both NHS and independent sector (IS) providers can form and run a single and multisite Trusts. IS providers are more likely to run elective care centres or specialist services. NHS providers may provide both acute and elective care as single and multisite Trusts.

# Key considerations

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

**Single and multisite Trusts are likely led by a well-performing organisation that expands by acquiring smaller and/or poorly performing Trusts.**

### Which presenting challenge or opportunity does the form suit best?

Need for additional capacity, strategic choice of acquiring/developing new specialities/geographical locations.

### Would the form be applicable to high performing organisations, those in difficulty or both?

Single and multisite Trusts are often led by a high performing hospital which acquires those judged to be unsustainable in their current forms. Financial/clinical unsustainability may make hospitals unable to achieve FT status on their own, and there may be regulatory pressure for them to be merged with another hospital or face dissolution.

### Does the form become more or less likely with greater imbalance in performance between providers?

More. More successful hospitals are likely to acquire the worse performing hospitals if they offer the strategic benefits sought (capture area, specialities etc.). Less successful hospitals are more likely to be acquired due to financial unsustainability and/or regulator pressure.

### Does the form primarily address clinical or financial concerns?

Both. If a poorly performing hospital is acquired the better performing hospital may share best practice, and service can be reconfigured and realigned to reflect the new larger organisation. Service reconfiguration, as well as asset reconfiguration (selling off unutilised land or other assets), or cash transfers can mitigate financial concerns.

### Could the form be used to make an unsustainable organisation viable?

Yes, to an extent. The acquiring Trust needs to be sustainable in its own right to acquire / build new site. Acquiring a deeply dysfunctional Trust is likely to be undesirable to a potential acquiringTrust, no matter how well performing it may be in its own right.

# Key considerations

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

**Single and multisite Trusts are usually multiservice providers, but can operate as specialist providers as well.**

### Is the archetype at a whole organisation scale?

Yes, single and multisite Trust archetype comprises the whole organisation. Single and multisite Trusts can also partner or be hybrid forms of service-level chains, management contracts or integrated care organisations, or be the foundations of these archetypes as well as multi-service chains.

### Does the form apply equally in or between non-specialist and specialist providers?

Single and multisite Trusts are usually non-specialist multi-service providers. In principle single and multisite Trusts could be specialist providers as well (such as Moorfields that also runs a service-level chain).

# Key considerations

## What is the role of organisational leadership in the form?

**Moving from single to multisite working and Mergers & Acquisition (M&A) processes require organisational leadership highly capable of change management.**

**In Mergers & Acquisition there are major changes to the Trust Boards – in acquired Trusts they are removed in entirety although individuals may secure positions in the new organisation.**

### Is the archetype collaborative or acquisitive?

The form can be both. Single and multisite Trusts are usually formed through M&A. M&A is nearly always executed on a congenial and collaborative basis, as local (community, political, and staff) support is needed. Opposition to the deal may cause it to fail. In practice the acquired organisation has little other options to acquisition as they are often in financially vulnerable situation and may face considerable pressure from regulators to merge with another organisation.

### Is the form led by a high-performing organisation or a partnership of equals?

Single and multisite Trusts need to be well performing both clinically and financially in order to stay sustainable. Where they seek to expand through M&A, they face a challenge of integrating another Trust culturally, managerially and financially. As the acquired Trusts may have some issues in some or all of those areas, this may be a considerable challenge.

### Is visionary leadership a necessary prerequisite?

No, but capability in change management is crucial. Single and multisite Trusts are a status quo option. Leadership highly capable of change management is crucial. Often acquired Trusts are pushed towards a merger because of difficulties they face or other concerns there may be regarding their operations. To deliver the changes in Trusts that are experience difficulties in one or more facets (cultural, managerial, financial, clinical) the acquiring organisation leadership needs to be highly capable of change and people management, to manage the financial and cultural implications of M&A, as well as the diversion of senior leadership time.

# Key considerations

## What is the role of organisational leadership in the form?

### Will one set of leadership be subsumed into another? If so, what is the incentive for the subsumed group?

Yes, and in pure acquisitions completely replaced. In the case of acquisitions the incentive to the subsumed group is often the pressure from regulators that are concerned with the financial or clinical viability of the acquired Trust or otherwise the viability of the Trust. In mergers there may be other strategic reasons (staff rotation, service reconfiguration, capturing new markets) that may act as incentives to the subsumed group leaders.

### What is the impact on the Trust Board or FT Governors?

M&A and new builds both present serious diversion of senior management time. The Trust board of the acquired Trust is replaced, or in the case of mergers, may be incorporated into the existing Trust board.

### Do current governance options enable the form to develop widely?

Yes. Single and multisite Trusts are the status quo form for NHS Trusts and FTs, and the governance options have formed to represent them.

# Key considerations

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

**Single and multisite Trusts are a flexible form that can interact, hybrid with and lead practically any other form.**

**Single and multisite Trusts can operate as hybrid arrangements with all other forms than the multi-service chain, and they can be the foundation blocks for all other forms, including multi-service chains. They can also operate as mutuals.**

| Hybrid with | Single and multisite Trust |
|---|---|
| Service-level chain | • Yes: Single and multisite Trust can act as either an outreach or host organisation to a service-level chain. |
| Multi-service chain | • No: By definition single and multisite Trusts are not leading or operating as part of a multi-service chain.<br>• However, a single and multisite Trust is likely to be the foundation of a multi-service chain, moving towards a chain structure through strategic decision-making and acquisitions in geographically non-contiguous areas. |
| Joint venture | • Yes: Single and multisite Trusts can operate in a joint venture with other organisations (e.g. EOC / Epsom and St Helier). |
| Federation | • Yes: Single and multisite can join federations, both loose and tight federations. |
| Management contract | • Yes: Single and multi-site Trusts could be under a management contract (e.g. Hinchingbrooke / Circle). |
| Integrated care organisation | • Yes: Single and multisite Trust can operate within an ICO.<br>• Yes: ICO is likely to be built on a foundations of a single and multisite Trust, either through organic growth or strategic decision-making. |

# Key considerations

## Does the form pass the three sense checks?

Three sense checks: single and multisite Trusts are a status quo in NHS, are functional and well established and their expansion is supported by well-known processes.

| | |
|---|---|
| **Does it make sense in the context described?** | **Single and multisite Trusts are a status quo form in the NHS and are therefore well understood.** They are a sensible choice for most Trusts, and expansion of the Trusts via M&A is a relatively well-known process that may be easier to undertake and convince Trust Boards of rather than other, less-well known, approaches and organisational forms. |
| **Will it make a difference?** | **Single and multisite Trusts are in most cases functional and well established.** M&A where a successful Trust takes over a failing Trust can be used to correct the clinical and financial concerns in the acquired Trust, through sharing best practice, and clinical and asset reconfiguration. |
| **Is it feasible?** | Yes. Expansion of single and multisite Trusts through M&A is a well-known process that is supported by regulators and for which there are established practices and enlisting help from private sector (legal, financial, consultant) relatively straightforward. |

# Key considerations

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

**Moving from single to multisite working and undergoing a M&A process is often both a strategic and a defensive choice.**

### Defensive

- Mitigate potential future loss of business due to new or improved providers in proximity.
- Acquire a hospital to prevent other Trusts from entering the same market / geographical area – deflecting competition.
- Regulator pressure on failing organisations / if they are not acquired they may be dissolved.

### Strategic

- Potential for economies of scale.
- Potential for economies of scope.
- Increasing the volume of higher margin services.
- Reducing fragmentation and eliminating excess capacity.
- Improving clinical pathways.
- To acquire/improve certain specialisms.
- To capture certain patient population.
- Quality and efficiency benefits of concentrating services, building larger clinical teams.
- Providing more varied opportunities and career paths for staff, in order to attract and retain the best staff.
- Sharing scarce management and clinical resources.
- Rotate staff across sites, particularly for 24/7 working requirements.
- Opportunities to utilise assets and resources across a wider number of sites.
- Synergies in administration and back office.

# Key considerations

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

**Barriers to moving from single to multisite working and M&A are myriad, with costs in terms of money and time particularly important.**

### Technical

- Different cultures between Trusts → may be difficult to integrate.
- Problems in acquired Trust (financial, managerial, clinical, cultural) may be structural and impossible to change.
- Poor quality business case.
- Resistance from the acquiring Trust Board of Directors – not all may see the acquisition as worth the risk.
- Competition regulations may prevent the move.
- Cost (legal costs) and length of approval processes – may be considerable and still end in a rejection of the case.
- Diversion of senior management time.
- M&A a considerable management challenge, needing robust planning and strong change management leaders.
- Increased regulatory burden during and following process.
- Estate legacy issues – what to do with estates not needed anymore?

### Strategic

- There may be no appropriate Trusts to acquire in the vicinity of the expanding Trust.
- There may not be large enough population to benefit from expanding Trust.
- Media and public perception – local opposition can lead M&A to fail.
- Perception of competition rules, and understanding how competition and choice fit into the overall priorities of NHS.
- Understanding the regulatory regime around competition and choice.
- Stressed financial climate – devising and implementing a merger/acquisition is risky and costly.
- Some mergers are driven by short-term factors, and/or by executive-level push. They can be undermined by poor strategic insight and weak implementation.
- There may confusion about the respective roles of the CMA, Monitor, TDA and commissioners in supporting or challenging distressed Trusts.

# Key considerations

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

### Support

- Simple process / less approval stages → time spent on different stages can be considerable.
- Increased cohesion between regulators e.g. Monitor, TDA, CMA, DH to make the M&A process faster and clearer.

### Incentives

- Develop and share positive case studies.
- Financial rewards to lock good managers into a merged Trust.
- Where a failing Trust is being acquired an investment fund for 'acquisition teams' and/or the ability to have a grace period with a trajectory that the acquiring organisation is held to account against for finance, quality and performance metrics.
- However, all mergers, acquisitions and moves from single- to multisite or vice versa, should be based an a (mutually beneficial) business case.

# Contents

## Multi-service Chains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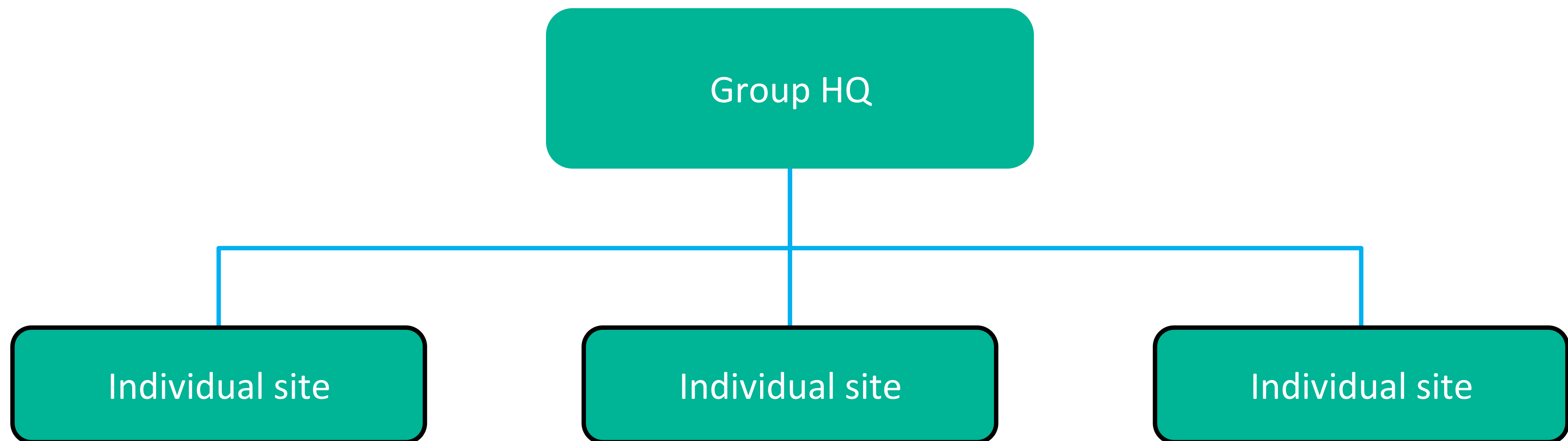
# What is the form?

Multi-service chains are single entities that own and operate multiple stand alone hospitals under the leadership of a single unitary Board of Directors



# What is the form?

## Multi-service chains use standardised operating practices and shared back office functions to achieve consistency of service quality across multiple sites

| Organisational sovereignty | Assets | Intangibles | Range of services | Scale |
|---|---|---|---|---|
| Single organisation, individual sites operate within framework of delegated responsibility. | Single asset holder (or operated by one entity under contract. | Standardised pathways and procedures across the chain. | Up to full range, may vary between individual sites. | Regional, national or international. |

**Key features:**

- Single organisation operating multiple sites to deliver services to multiple populations.
- Achieves value by driving high quality, efficient care through standardisation and consolidation of support functions.
- Not geographically defined – typically regional, national or international scale.
- Headquarters exercises strategic leadership and sets quality and financial frameworks.
- Individual sites have operational autonomy within framework set by headquarters.
- Typically formed through defined corporate strategy, not organic expansion.
- Expansion into new sites typically through acquisition of other providers.
- Potential competition issues over acquisition of local competitors and accumulation of market power.

# What is the form?

## Multi-service chains share some common features with large multi-site Trusts, though there are also important differences

**Research to date suggests some common features in the organisation and governance of multi-service chains in other health systems and other sectors.**

**Some of these features are already present in multi-site Trusts but there are some important differences, especially in multi-service chains that manage large numbers of sites and/or work across large geographies. When does a multi-site Trust start to become a chain or Foundation Group?**

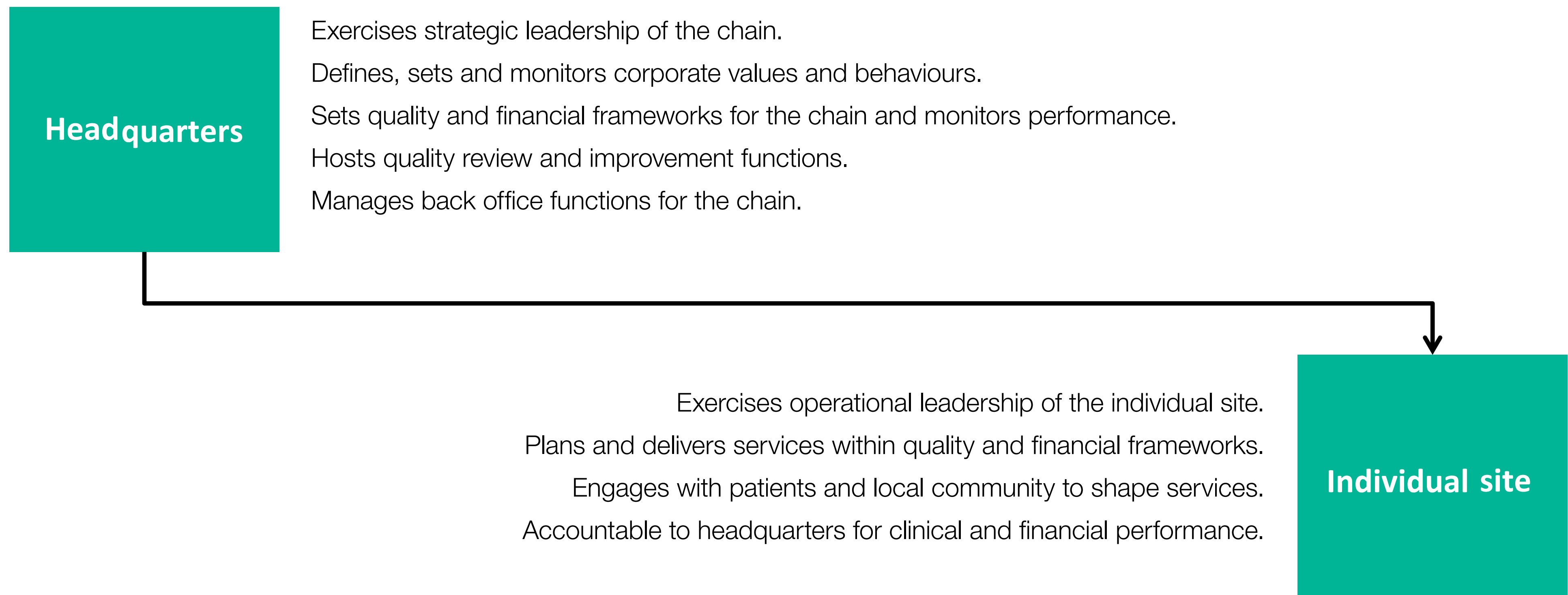
**The table attempts to pull out some of the key differences and challenges:**

| Multi-site Trust | Multi-service chain |
|---|---|
| Single organisation operating services from multiple sites. | Single organisation operating services from multiple sites. |
| Contiguous – clustered in single local geography. | Contiguous or non-contiguous – can be spread across several geographies. |
| Centralised leadership, single Executive Team provides strategic and operational leadership across all sites. | Decentralised leadership, headquarters provides strategic leadership, operational leadership devolved to individual sites. |
| Proximate sites servicing single population, so strong potential to rationalise clinical services and activities. | Distant sites servicing multiple populations, so limited potential to rationalise clinical services and activities. |
| Some potential to drive standardisation of best practice via internal benchmarking due to strong potential for rationalisation and less duplication of services. | Strong potential to drive standardisation via internal benchmarking due to greater duplication of services and lower potential for consolidating services. |
| Possible economies of scale through service rationalisation and unified and support functions. | Possible economies of scale through unified support functions. |
| Possible diseconomies of scope from complexity of providing large number of specialties. | Possible economies of scope from split between headquarters and individual sites. |

# What is the form?

## The large number of sites and the regional or national presence of multi-service chains tends to be reflected in their organisational structure

**With some exceptions, multi-site Trusts tend to operate a unitary structure which allows the Executive Team to have a direct line of sight to the wards. Multi-service chains, operating many sites across multiple geographies, need the flexibility to adopt a more decentralised structure. Some very large chains utilise a regional tier, but most generally use a variant of the headquarters/individual site split:**



# What is the form?

## Operational management needs to be devolved with headquarters retaining a critical role in setting standards and holding individual sites to account for performance

**An NHS multi-service chain may need to constitute itself differently to the current organisational form used by most multi-site Trusts. The difficulties of maintaining lines of site from the unitary Board of Directors to the quality of services provided in each part of a large, non-contiguous multi-service chain means operational autonomy needs to be accompanied by formal accountability. It is assumed that multi-service chain (Foundation Group) would only be available to FTs or NHS Trusts joining together to become a chain for the purposes of becoming authorised.**

**Applying the forms used by existing chains to the NHS would suggest:**

| | |
|---|---|
| **Headquarters** | **A single unitary Board of Directors for the chain as a whole:**<br>• Unitary Board of Directors comprising Chair, Non-Executive Directors, Chief Executive, Group Medical Director, Group Nursing Director, Group Finance Director, etc.<br>• Responsible for strategic leadership of the chain, delivery of cross-cutting functions and holding individual sites to account for clinical and financial performance.<br>• Chair and Non-Executive Directors appointed by Council of Governors , CEO appointed by the Chair and NEDs with a confirmatory vote from the Council of Governors and Executive Directors appointed by CEO, Chair and Non-Executive Directors.<br>• CEO is the Accounting Officer, as set out in the NHS Act 2006. |
| **Individual sites** | **A management team for each individual site, accountable to the Board of Directors:**<br>• Executive committees comprising Hospital Director (Managing Director role), Medical Director, Nursing Director, Finance Director etc.<br>• Responsible for operational leadership of the site within the strategic, quality and financial frameworks set by the unitary board.<br>• Directors appointed by, and accountable to, the unitary Board of Directors.<br>• Hospital Director is the Accountable Officer. |

# What is the form?

## Frontline staff tend to be heavily involved in determining standards for multi-service chains, with headquarters playing a facilitative role and reserving final approval

**Headquarters plays an important role in setting standards for multi-service chains, but this is not done in isolation. Chains have a range of formal and informal mechanisms for engaging relevant frontline staff in shaping the development of standards.**

**This process is led by headquarters, which also retains final approval of the proposed standard. This means that, while individual sites are expected to comply with the standards set by headquarters, frontline staff will have been strongly involved in their development.**

| Stage | Headquarters | Individual site |
| --- | --- | --- |
| **Initiation:** impetus to develop new standard to reflect changes in practice/evidence. | Head-quarters | Individual site |
| **Development:** involvement in development of new standard or review of existing standard. | Head-quarters | Individual site |
| **Approval:** formal authorisation of new or revised standard. | Head-quarters | |
| **Implementation:** demonstrating ongoing compliance with new standard and feeding back on experience. | | Individual site |

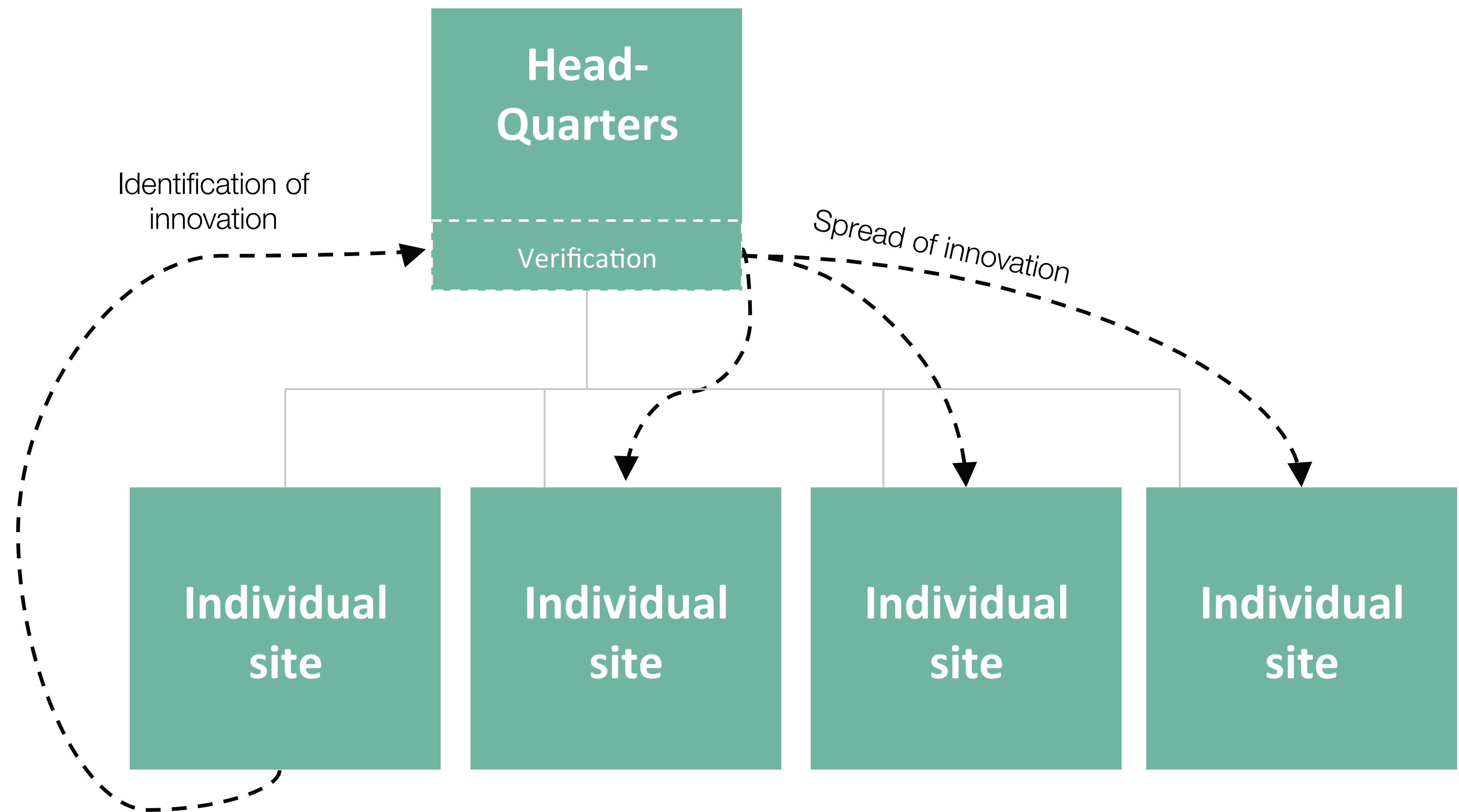
# What is the form?

## Feedback loops are used to ensure that compliance with standards mandated by headquarters does not create perverse incentives or hinder innovation

**Standardisation of systems and processes may reduce unnecessary variation but could potentially restrict innovation and prevent better ways of working. In some instances, standards set in good faith may prove difficult to implement locally and an overly rigid approach to compliance could give rise to perverse incentives. Chains have a number of mechanisms to mitigate these risks:**

Some multi-service chains have feedback loops to encourage continuous improvement and enable the rapid systematisation of innovation.

Some have developed physical and virtual forums for sharing best practice and actively reward staff for suggesting new ideas.

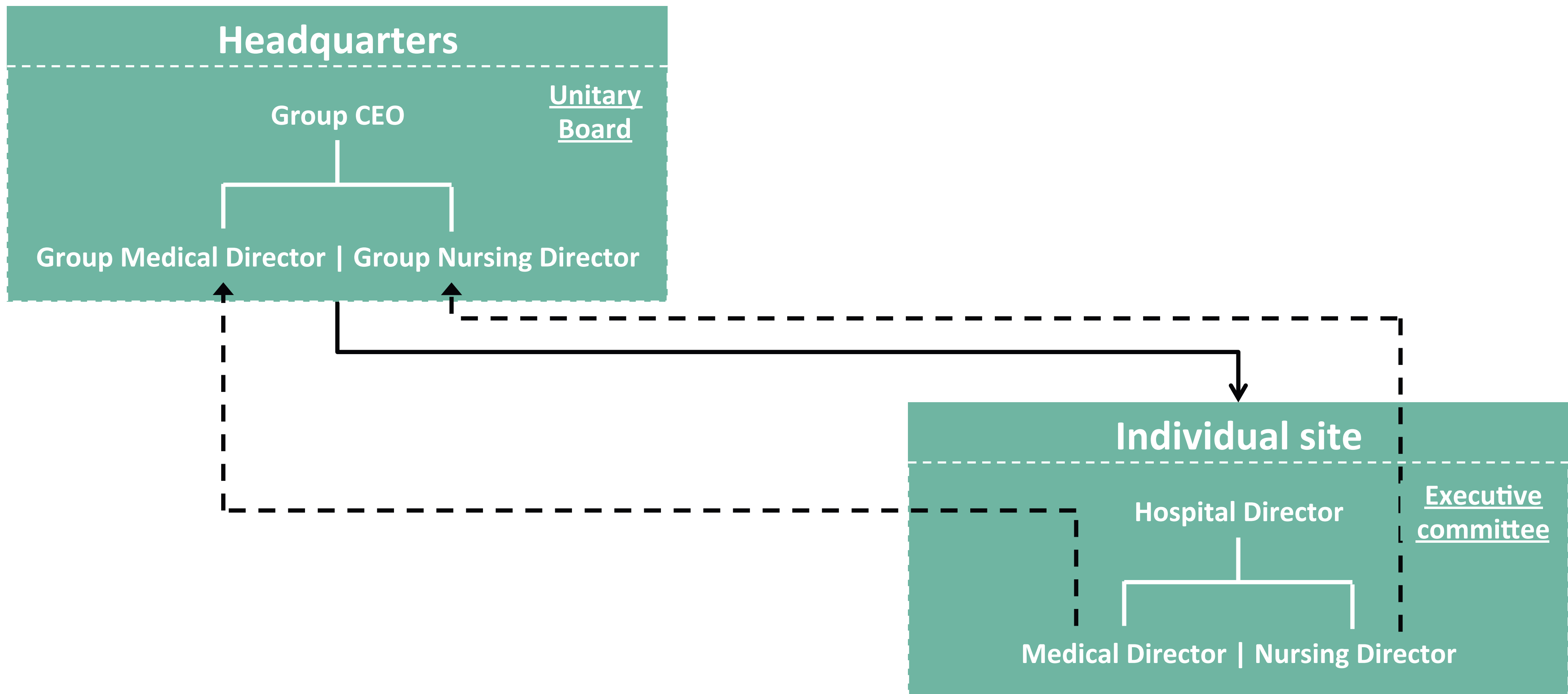


# What is the form?

## Matrix working to maintain professional oversight and accountability also seems a relatively common feature of multi-service chains

**Individual sites within multi-service chains tend to be run by an executive team led by a hospital director who has overall accountability for the site.**

**The rest of the Executive Team – which typically comprises medical, nursing and potentially finance directors – are managerially accountable to the Hospital Director with a dotted line of professional accountability to the relevant head of profession for the group.**



# What is the form?

## Existing Foundation Trust forms of membership and local accountability need to evolve to maintain those benefits in a multi-service chain

**Patients, the public and staff could become members of the chain and choose to be affiliated to an individual site. Members would be consulted on plans for the future development of the chain and their affiliated site. Within this, there appear to be two main options for how members influence the development of a multi-service chain:**

| | |
|---|---|
| A single, overarching Council of Governors | **A single, overarching Council of Governors for the whole chain.** Less bureaucratic than maintaining multiple Councils of Governors and ensures strong, direct accountability of Board of Directors. Each local membership elects patient and public governors to the chain's Council of Governors, which holds the unitary board to account. Would involve some Governors having to travel long distances, which may discourage a representative range of members putting themselves forward for election. |
| A single Council of Governors with a stronger role for local members | **A single overarching Council of Governors for the whole chain, with a formal role for local committees of members.** Less bureaucratic than maintaining multiple Councils of Governors and ensures strong, direct accountability of both Board of Directors and executive committees, but still relatively complex. May still require Governors having to travel long distances. |

# What is the form?

## There are also issues to consider around how NHS multi-service chains would need to be regulated by the Care Quality Commission and Monitor

### Care Quality Commission

**NHS Trusts and Foundation Trusts are currently required to be registered with, and inspected by, the CQC against the fundamental standards of quality and safety.** Although different sites managed by a Trust may be registered to provide different services, the Trust is treated as a single entity for the purposes of regulatory action.

**Large chains of private hospitals are required to meet the same fundamental standards but are treated differently.** The chain registers as a corporate body with a registered manager (typically the Hospital Director) nominated for each individual site that delivers services. Individual sites are inspected separately with the governance arrangements with the chain taken into account. If the CQC finds that standards have been breached at an individual site, any resulting regulatory action can be taken against the registered manager and/or the individual site rather than the chain as a whole.

**A similar approach could be extended to NHS multi-service chains.**

### Monitor

**Providers of NHS services are currently required to be licenced by Monitor, with exemptions for NHS Trusts and lower turnover providers (<10m turnover).** Licence conditions include enabling integrated care, preventing anti-competitive behaviour, upholding patient choice, complying with NHS tariff and supporting continuity of services.

**Monitor also has an additional set of transitional powers over Foundation Trusts.** This enables Monitor to continue its oversight of FTs and take regulatory action where poor governance is likely to cause the FT to breach its licence conditions. Such action could include removing, suspending or disqualifying one or more members of the Board of Directors or Council of Governors from office.

**It may be appropriate for an NHS multi-service chain to operate under a single licence from Monitor.** Financial and governance risk could be rated for the chain as a whole rather than each individual site. The Board of Directors would be able to remove, suspend or dismiss executive committee members, so Monitor's powers of intervention would apply to the Unitary Board of Directors , as set out in statute, only.

## Case studies for the multi-service chain (Foundation Group) form

# Case study

## Multi-service chains dominate the private hospital market but none yet exist in the NHS, so we have undertaken case studies of multi-service chains in other countries will need

**BMI Healthcare** is the largest independent healthcare provider in the UK, operating 69 hospitals and treatment centres (incl. Wales and Scotland) and 2 consulting suites in London. This includes 5 emergency care departments.

BMI has an established quality and clinical governance structure covering the hospital, regional and corporate level. This covers standard setting, implementation and monitoring overseen by national, regional and local clinical governance boards and medical advisory committees.

Internationally, BMI is part of a very large network with frequent transactions, acquiring 9 hospitals in 2008, two more in 2010 which were sold by 2012.

Source: bmihealthcare.co.uk

Visits to hospital chains in other health systems explored the following areas:

- Enterprise structures and strategies for organisational development.
- The motivations and drivers behind multi-service chain and ICO forms.
- The challenges and barriers faced in organisational development.
- Strategies for the creation of value(e.g. standardisation).
- The creation of a collective, organisational culture and values.
- Lessons for the NHS.

# Case study

## Research commissioned from RAND Europe suggests the individual sites within multi-service chains have significant operational autonomy within a framework

**The organisational structure of multi-service chains tends to consist of a corporate headquarters and the individual sites delivering services, with some larger chains also incorporating a regional tier. Agaplesion, which operates 90 facilities including 29 acute hospitals across Germany, appears typical:**

Agaplesion sets corporate strategy through a “unifying strategic framework”, which forms the basis for planning at regional level. Local partners have a substantial amount of autonomy to work within this strategic framework and retain leadership on core operations such as medical services, nursing and care.

A number of back office and support functions are run from Agaplesion’s headquarters in Frankfurt am Main, including quality management, accounting and financial management, controlling, procurement, human resources, information technology, internal audit and an in house management training and development facility. These central services oversee implementation of company-wide directives and frameworks as well as disseminating best practice and assisting in problem solving.

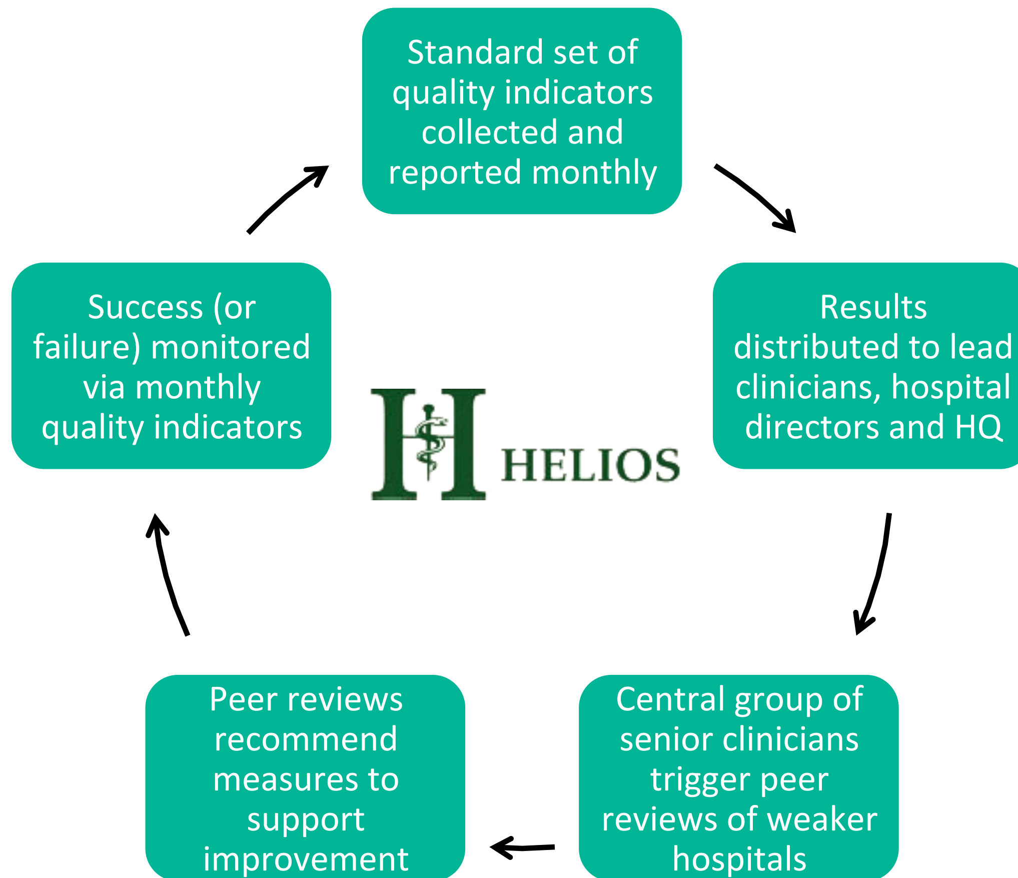
Headquarters also facilitates discussions about standard setting and innovation across the chain to generate proposals for agreement by the Agaplesion management board.

*RAND Europe, 2014*

# Case study

## Other literature suggests that the HQ of multi-service chains plays an important role in holding individual sites to account for delivering consistently high standards

**Helios Hospital Group operates 109 facilities including 56 acute hospitals across most of Germany. It has developed an outcome-driven quality management system for acute hospital services based on a five stage improvement cycle:**




A study of 18 hospitals subjected to this approach following acquisition by Helios from 2003-2013 found hospitals with low pre-acquisition mortality rates stayed low, whilst mortality at hospitals with high pre-acquisition rates improved significantly.

*Nimptsch and Mansky, 2013*

# Key considerations

## What are the scenarios in which the form could apply?

- The significant features of the form include standardisation of systems and processes with a strong role for the chain's headquarters in holding individual sites to account for delivering a consistent level of service performance.
- Within this framework, however, there may be a degree of scope for variation in how each site operates and particularly the range of specialties and services it provides. Indeed, experience from analysing chains in other health systems and other sectors suggests that individual sites may be given a relatively broad degree of autonomy to develop their services in the way that best meets local need.
- Multi-service chains could potentially operate in a wide range of scenarios, serving a wide range of different populations in different parts of England. As separate sites linked into a broader network with a common set of systems and processes, it may be possible for chains to operate sustainably in situations that would be unsuitable for some types of standalone organisations.
- Chains are likely to be formed through the acquisition of poor and adequate Trusts by high performing providers. While multi-service chains are expected to be largely non-contiguous to avoid issues with competition law, there may be instances where a multi-service chain is able to acquire a neighbouring organisation if patient benefit outweighs the loss of competition. Either way, expanding through acquisition will be extremely challenging and will require the chain to devote significant amounts of leadership capacity and capability to integrating new sites.

# Key considerations

## Does the form apply across some or all geographical circumstances?

- Multi-service chains could potentially operate across all geographical circumstances through their ability to support individual sites through standardised processes and unified back office and support functions.
- As separate sites linked into a broader network with a common set of systems and processes, it may be possible for chains to operate sustainably in situations that would be unsuitable for some types of standalone organisations.
- The chain is likely to be required to devote considerable leadership capacity and capability to integrating newly acquired sites into the chain. This will clearly be significantly more difficult where the new acquisition is difficult to access from existing sites.

# Key considerations

## Does the form apply across different health economies?

- Multi-service chains could operate sites in a number of different types of local health economy, subject to each site being able to generate enough income and realise efficiencies to cover its costs. It may be possible for a multi-service chain to cross-subsidise a small number of sites that are unable to generate a surplus. The additional financial risk associated with doing so, however, may only be justifiable in locations where the chain's site is the only provider of essential services.
- The non-contiguous nature of multi-service chains strongly limits the potential for rationalising service provision. This is likely to limit suitable acquisitions to other FTs and Trusts that are already clinically and financially viable or those that can be made so through sharing back office and support functions with the chain, reducing unnecessary variation or resolving recruitment problems. Acquisitions of FTs or Trusts with more deeply rooted sustainability problems, particularly those where whole health economy solutions are required, are unlikely to be suitable for multi-service chains.

# Key considerations

## The form may be realised differently by FTs and IS providers

### Foundation and NHS Trusts

FTs and NHS Trusts can already expand to acquire or merge with other FTs and NHS Trusts.

A small number of FTs have started to form chain-like structures to operate a large number of sites but these tend to be clustered within relatively small geographical areas.

For example Central Manchester University NHS FT which operates eight sites in Greater Manchester and Central and North West London NHS Foundation Trust which operates services across the country. Both have considered the governance form required for the Trust Board to continue to be able to have assurance across all the sites.

### Independent Sector providers

IS providers can and do form multi-service chains as owner-operators across different health economies, both in provision of NHS-funded services and for self-funded or privately-insured patients.

The scope for IS providers to acquire NHS-owned assets to provide NHS-funded services is currently severely limited, but IS providers may be able to take on the operation of those assets through management contracts and operational franchises.

It may therefore be possible for IS providers to form an NHS multi-service chain by holding two or more management contracts or operational franchises for NHS Trusts or Foundation Trusts.

# Key considerations

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

- Organisations with significant financial problems and/or those located in local health economies that face complex challenges beyond the boundaries of the organisation may not be suitable to become part of a multi-service chain. This is unless it is possible to overcome these issues through financial incentives, e.g. write-off of large historic deficits or commissioner-approved above tariff payments, or by driving through changes in the wider health economy.
- The acquisitions made by multi-service chains are likely to be lower performing organisations that can benefit from the stronger leadership, higher standards and support structures offered by the chain. This may include organisations that are clinically and financially viable but need to improve standards, viable organisations that are poorly led or organisations that can be made sufficiently viable through becoming part of a chain. To do this multi-service chains would need to have a clear strategy for the growth and development of its services. This would need to provide clarity about the chain's:
    - motivations for expanding.
    - methodology for integrating new acquisitions into the chain.
    - managing the associated risks.
    - plans for extract value from expansion for both its patients and itself.
- Chains would also need to possess sufficient leadership capacity as taking on new acquisitions consumes significant management time and energy. The chain will need to have sufficient leadership headroom to devote to integrating new acquisitions as well as being able to maintain performance on its other sites. The chain may need to consider how it can bring in additional management capacity during the transition period, either to support performance in existing sites or to support transformation in the new acquisitions. Chains would also need to have the capacity to support transformational change. As well as codifying the operating framework, procedures and protocols, the chain will need to be able to undertake the cultural change required to successfully integrate new acquisitions. Though not impossible, even acquiring organisations in only moderate difficulty is likely to present significant challenges for the chain.

# Key considerations

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

- This archetype primarily applies to multi-service organisations that operate all or most of the services and specialties delivered on each site that it owns. Service-level chains, which operate a single specialty or service on a satellite basis at sites owned by a host organisation, are explored separately.
- The primary source of value in multi-service chains is its ability to improve quality and operational efficiency in newly acquired sites by deploying the proven operating frameworks, procedures and policies developed on existing sites. This means the applicability of the form is likely to depend on whether the chain has the specific capabilities, expertise and structure required to make significant improvements in the services provided by a potential new acquisition.
- A specialist, single speciality provider is therefore unlikely to present a suitable acquisition for a non-specialist multi-service chain that does not currently provide that speciality as the applicability of existing policies and procedures will be limited. It may, however, be possible for a specialist, single speciality provider to acquire a non-specialist multi-service provider if there is sufficient transferability of existing policies and procedures. For example, a specialist cancer provider may be able to extend their expertise to general surgery.

# Key considerations

## What is the role of organisational leadership in the form? (1)

- Hospital chains in other countries have tended to expand by investing in the construction of new facilities or by acquiring, wholly or partially, other hospitals or groups of hospitals.
- Hospitals may initiate the search for an acquiring organisation themselves, or where directed to do so by shareholders, trustees or an external body such as a regulator. Some acquisitions may take the form of hostile takeovers but this does not appear to be the dominant type of transaction.
- Others freely enter into a multi-service chain on a more collaborative basis, surrendering a degree of autonomy in order to benefit from the chain's systems and processes, unified support functions and, potentially, branding. The German chain Agaplesion, for example, takes a 60% stake in new acquisitions in exchange for voting rights in its general assembly.
- Multi-service chains in the NHS seem most likely to be formed through existing high performing providers acquiring and integrating new sites into their existing operations. Making this form a success will require new acquisitions to be successfully integrated into the chain, which is likely to require significant management time before and after the acquisition.

# Key considerations

## What is the role of organisational leadership in the form? (2)

- The process of forming a multi-service chain necessitates the acquirer to shift to a management system with a corporate headquarters and individual sites. The Trust Board for the original site will need to establish a headquarters function with the necessary skill set, disengaged from the operational management of the site. An Executive Committee will be appointed to undertake that the day to day management role . Headquarters will need to shift their focus to exercising their role across all sites. Standardised operating frameworks, procedures and policies will also need to be formalised in order to be duplicated on the new site.
- This will be a challenging shift in mindset for NHS Boards who are used to being the Trust Board for the primary organisation and in many cases have been used to 'being able to get their arms around the organisation'. In this form, the subsidiaries will all be of equal standing in the structure.
- The process of expanding an established multi-service chain will still require a significant investment in time and energy to integrate the new acquisition into the chain. This will include embedding standardised operating frameworks, procedures and policies, increasing capacity in headquarters functions, appointing the executive committee for the newly acquired site and removing surplus capacity. Distance between sites and/or headquarters may make this process more difficult. A large, established multi-service chain may be able to maintain some dedicated capacity to undertake new acquisitions. Alternatively, a chain could seek to buy in temporary additional capacity.
- It may also be possible to harness the benefits of the multi-service chain form through a tight federation of several provider trusts, though the barriers would be significant. It would require member Trusts to surrender significant amounts of organisational sovereignty and agree to be accountable to the leadership team of the federation, which would need to be separate from member Trusts. In the absence of a clear acquirer/acquiree split, it would also be more challenging to integrate Trusts into a more standardised way of working.
- The current "all-or-nothing" nature of Trust and NHS FT acquisitions means it is not currently possible to develop an Agaplesion-style chain form where one provider takes a controlling but less than total interest in another.
- The current risk is there is only an acquisition but not a disinvestment route, which means organisations can only get bigger. This limits the social entrepreneurship and fleet of foot nature that the independent sector chains are able to operate.

# Key considerations

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

- Multi-service chains do not currently exist within the NHS so could co-exist with a number of other archetypes as they form and develop.
- Multi-service chains may grow out of existing multi-site Trusts and could also develop service-level chains in specialties where they have particular expertise. Chains could also enter into joint ventures with other providers to expand their services and enter into management contracts or operational franchises to support turnaround at struggling providers without acquiring those assets.
- The individual sites in a multi-service chain could develop hospital-led ICOs, potentially in order to help mitigate the impact of wider health economy issues.
- Multi-service chains are unlikely to enter into tight federations, as being a chain means they will have already captured the relevant benefits. Loose federations to support the coordination of academic research may offer some benefits.

# Key considerations

## Does the form pass the three sense checks?

| | |
|---|---|
| **Does it make sense in the context described?** | Evidence from the multi-service chains that exist in the health systems in other countries and other sectors in the UK suggests the form is applicable to the context of the NHS in England – Foundation Groups. |
| **Will it make a difference?** | There is also some evidence to suggest that multi-service chains can drive up standards of care in poorer performing hospitals by setting clear standards, monitoring performance and exercising strong but support accountability for improvement. For example, the quality management system used by the German chain, Helios, has been associated with improved outcomes in newly acquired poor performing hospitals. |
| **Is it feasible?** | On balance, it should be possible for an FT or NHS Trust to establish a chain. It should be noted that NHS Trusts forming a chain would most likely be in the context of the new entity being authorised.<br>Some FTs have started to develop chain-like structures but these tend to be geographically clustered. Chains in other countries and the UK private hospital sector operate at national level, but tend to run significantly smaller hospitals than the NHS (though not exclusively so). |

# Key considerations

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

**The motivations for developing a multi-service chain are a mix of strategic and defensive. The formation of a multi-service chain may be expected to be driven by desires to:**

- Spread best practice through an ability to drive uniformly high standards of clinical care across numerous hospitals by the acquiring FT codifying its operating framework, procedures and protocols and standardising these across the newly acquired NHS Trusts.
- Gain broader opportunities to drive continuous quality improvement across the whole chain through benchmarking similar services on different sites, systematising peer review and support, operating a dedicated quality improvement resource and realising the benefits of innovation by faster adoption at scale.
- Achieve economies of scale by eliminating duplication in back office and support functions, as well as being able to support greater specialist expertise in functions such as specialist procurement and asset management. There is also some potential for reducing management costs and rationalising service provision, as well as by reducing unnecessary and costly variations in clinical practice and outcomes.
- Achieve economies of scope – potential for decentralised organisational structure from individual sites each having a dedicated executive team that exclusively focuses on operational delivery and service quality.

# Key considerations

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

- A mix of barriers currently exists to developing multi-service chains in the NHS.
- Taking on new acquisitions consumes significant management time and energy, so the chain needs to have sufficient leadership headroom to devote to integrating the acquired sites as well as being able to maintain its own performance. The chain may need to consider how it can bring in additional management capacity during the transition period, either to support performance in existing sites or to support transformation in the new acquisitions.
- The chain also needs to have capacity for driving transformational change in new acquisitions. As well as codifying the operating framework, procedures and protocols, the chain will need to be able to undertake the cultural change required to integrate new acquisitions.
- The risk associated with undertaking transactions may be too great in relation to any benefits gained, especially where the acquired organisation is failing or has issues with clinical or financial sustainability. If the chain has no links into the wider health economy surrounding its new acquisition this may also be problematic.
- There are no insurmountable legal barriers to the adoption and development of a multi-service chain structure within the existing FT legal framework.

# Key considerations

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

- The disincentives to forming a multi-service chain through acquisition are at least as significant as acquiring a neighbouring Trust, plus the additional difficulties of working over longer distances to integrate the acquired Trust into the chain.
- Financial incentives may be required to neutralise the disincentives associated with taking on and assimilating a new Trust into a chain. Prospective chains may also benefit from support to help develop their enterprise strategy and a clear methodology for integrating newly acquired Trusts into the chain.
- There may also be a case for amending the legal mechanisms for merger and acquisition to make them more workable and less onerous to undertake in practice.

# Integrated care organisation

## Integrated Care Organisation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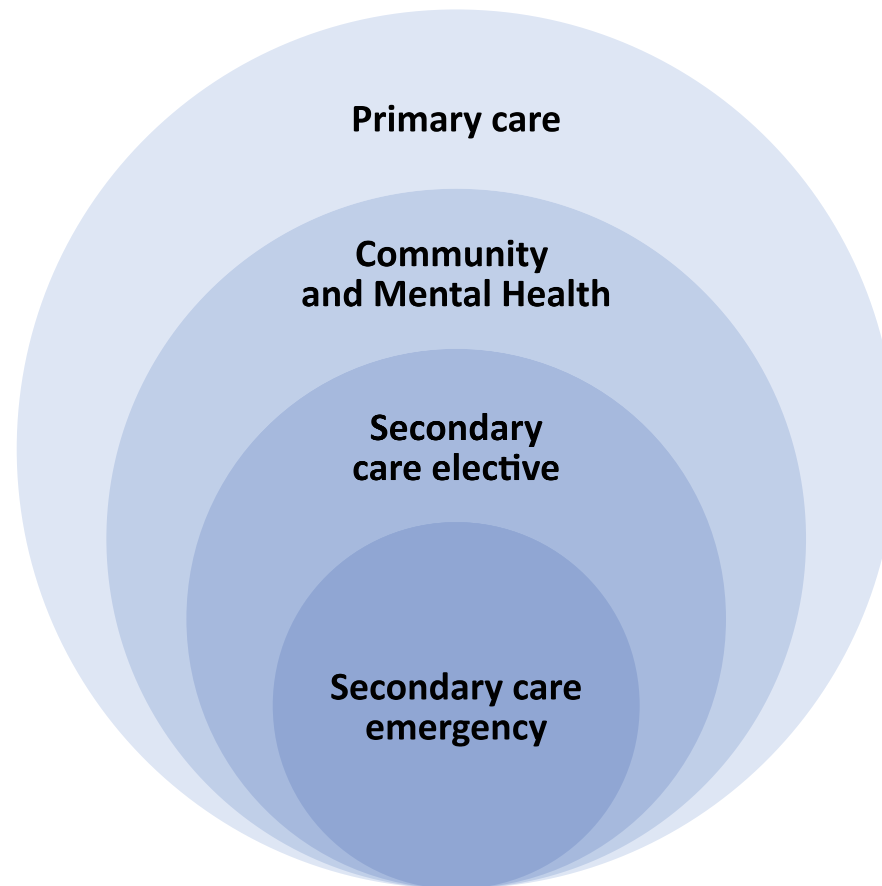
# What is the form

## Hospital led Integrated Care Organisation

**Formal or virtual vertically integrated organisation from primary to acute service levels, often serving a defined population.**



# What is the form?

## ICOs are created through structural or virtual integration of organisations at several service levels, from primary to secondary elective and emergency

| Organisational sovereignty | Assets | Intangibles | Range of services | Scale |
|---|---|---|---|---|
| Depends on form – may form new organisation or combine through contracting. | Some sharing of assets. | Different methodologies across organisational tiers due to different service offer, but consistent approach overall. | Full range, including primary and community. | Local – defined population. |

**Key features:**

- Currently no defined contractual mechanism for formal ICO in English NHS but can be formed through bespoke agreements.
- Increasing interest in UK context, in line with greater service provision in community and emergent forms of out-of-hospital care (OOH).
- A number of pilots and early adopters are exploring accountable care forms with their local commissioners and national bodies; forming ICOs is a usual first step on this pathway.
- 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 return on investment only in the longer term.
- The form can apply in any local situation, but pricing and contracting should vary to suit local circumstance.
- It should be noted that the NHS Forward View (published October 2014) describes Primary and Acute Care Systems (PACS) which could be a variant on the ICO forms described here.

# What is the form?

## The 2008 NHS Next Stage Review emphasised ICOs as a means to achieve better care for patients, but to date there has been limited progress towards this

| | |
|---|---|
| **Organisations** | Organisations rooted in general practice, which is the only part of the current health system with an enrolled patient population and is closest to the role of care coordinator across providers. ICOs could evolve multi-specialty clinical groups, like some of those seen in the US, in which generalists and specialists work in the same organisation with more opportunity to work collaboratively than is currently the case. However, the precise constitution of ICOs should be determined by local circumstances. |
| **Budgets** | Budgets set using risk-adjusted capitation methods to provide strong incentives to manage resources effectively (and potential for the organisation to be rewarded for its efficiency). Capitation budgets would provide incentives to invest more in upstream prevention – keeping patients healthy today would save money in later years. |
| **Contracts** | ICOs would formally contract with PCTs (now CCGs) to deliver the agreed range of services.<br>The ‘virtual’ nature of practice-based commissioning does not provide sufficient power or accountability for integrated care to be delivered at scale. |

# What is the form?

## ICO and ACO forms are built on four pillars which can vary to suit any local circumstances

| | |
|---|---|
| **Incentives** | Incentives and governance arrangements are aligned to support shared goals and effective collaboration. This is achieved through the most appropriate contracting mechanism for the providers involved. Pricing will depend on local population makeup. |
| **Patient centred** | Arrange teams and processes around the patient to provide a seamless care pathway irrespective of organisational boundaries. |
| **Leadership** | Effective leadership and collaborative relationships, including surrendering aspects of self determination where necessary. |
| **Data** | Single or compatible systems providing patient and service level data on cost and outcomes.<br>This will also determine the pricing and risk stratification which is crucial to the success of the form and the ability of commissioners or lead providers to monitor contracts and ensure appropriate accountability. |

Lewis RQ, Rosen R, Goodwin N, Dixon J. (2010) Where next for integrated care organisations in the English NHS? The Nuffield Trust and The King's Fund.

# What is the form?

## ICOs are less strictly defined than ACOs and the increased accountability for costs and outcomes can drive further improvements

| | |
|---|---|
| **Concept** | ACOs are networks of healthcare providers who take on contractual accountability for coordinating all health care for a specified population, within a set budget or expenditure target and against an agreed set of outcomes indicators.<br><br>ICOs are typically formed of a similar range of providers but do not necessarily have accountability for a defined a population against set outcomes. Each organisation may operate under separate contract, including block provision. |
| **Membership** | ACOs and ICOs take a variety of different forms with different provider-types, but must include primary care. There are four main models, with increasing degrees of organisational integration: **independent provider associations; fully integrated health systems** (the NHS Forward View published October 2014 refers to these as Multi-Specialty Provider); **physician-hospital organisations; multi-specialty groups** (the latter two fall under the same definition as the NHS Forward View Primary and Acute Care Systems [PACS]). |
| **Governance** | To form an ACO, providers form a separate legal entity with its own governing body, commit to working together for a minimum number of years and cover a defined patients population.<br><br>ICOs do not have to be separate legal entities and may either follow the ACO structural form or be loosely configured affiliates. |
| **Payment & risk** | Payment models vary. In the USA, ACOs can elect not to accept any liability for any losses in which case they are eligible for up to 50% of potential savings, or they can accept a capped liability for some losses and retain up to 60% of any savings.<br><br>Each organisation in an ICO may have individual contracts or may be under an overarching contract. |


Deloitte Center for Health Solutions. Accountable Care Organizations: A New Model for Sustainable Innovation. 2010.

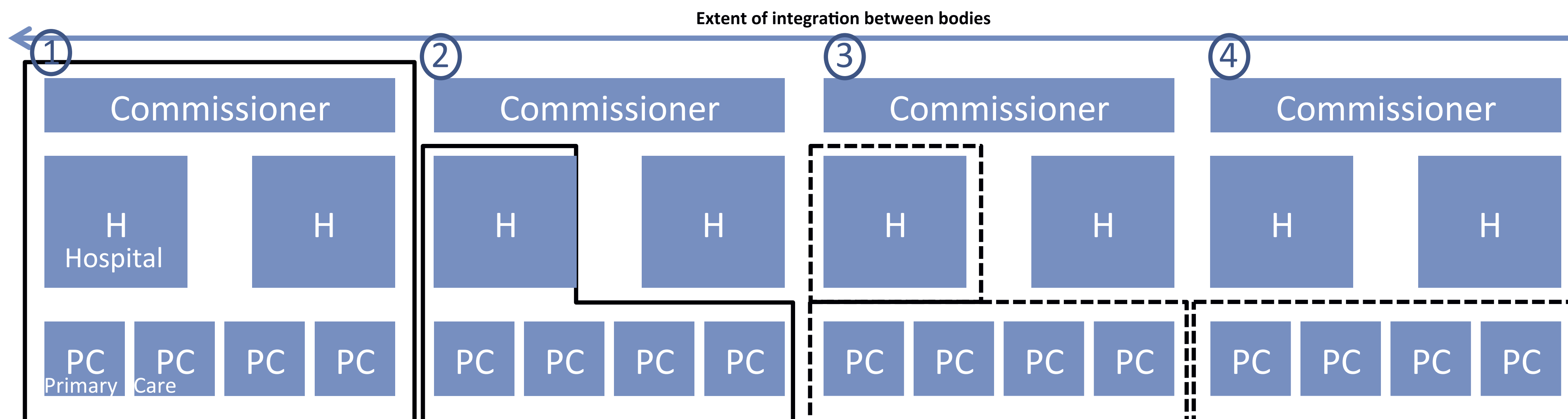
Available at: www.deloitte.com/assets/Dcom-UnitedStates/Local%20Assets/Documents/US_CHS_AccountableCareOrganizations_070610.pdf

*ACO/ICO/CPCI Comparison*. Kate McEvoy. Healthcare Innovation Central, State of Connecticut, 2011.

Available at: http://www.healthreform.ct.gov/ohri/lib/ohri/hcc.delivery_system.aco-ico-cpci_comparison.kmcevoy.pdf

# What is the form?

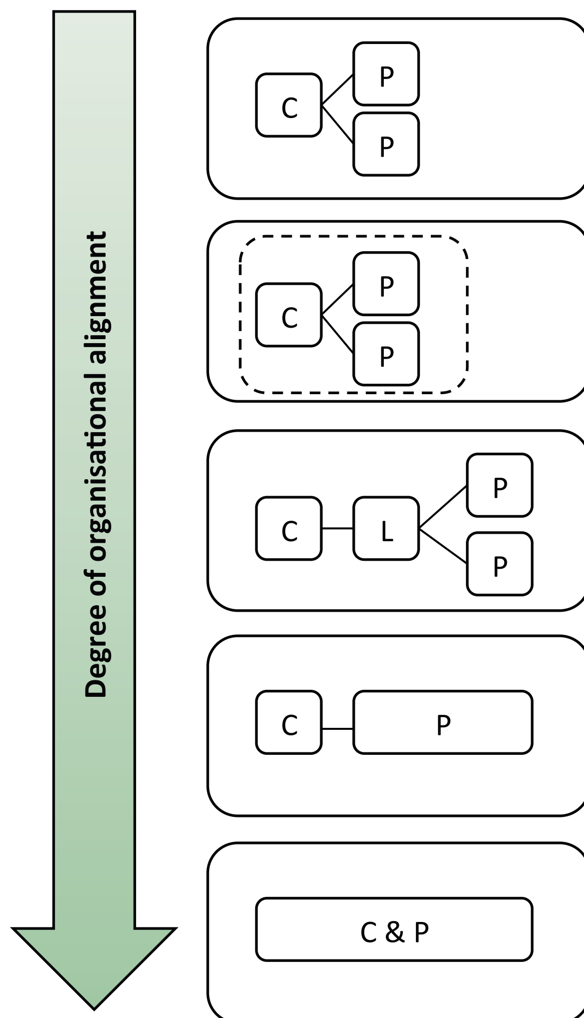
Most initiatives in the NHS are attempting to move from the right to left on the spectrum. It is likely that legal barriers prevent full integrated delivery services.




| | ① Integrated Delivery Services | ② Multi-Specialty Group Practices | ③ Physician-Hospital Organisations | ④ Independent Practice Association |
|---|---|---|---|---|
| **Service Design** | Typically own hospitals and other facilities but also have at least one salaried multi-specialty group practice and provide their own health insurance plan. | An umbrella organisation under which different specialty providers work together. Most either own or have a strong affiliation with a hospital but do not operate their own health plan. | Less formal arrangement based on alignment across clinicians and hospitals. PHOs contract with health insurers to deliver care for a defined population. | Individual physician practices that come together for the purposes of contracting with health insurers |
| **International examples** | Examples include: Kaiser Permanente, Geisinger Health System, Alzira, Intermountain Healthcare. | Examples include the Mayo Clinic and Virginia Mason in Washington State. | Examples include Advocate Health Care in Chicago. | Monarch in California. |
| **NHS Example** | Runs contrary to the purchaser/ provider split. | Milton Keynes CCG/Circle musculoskeletal contract. | Chelsea & Westminster Accountable Care Group. | North East Lincolnshire CCG. |

# What is the form?

## There are a number of contractual mechanisms to establish these forms which exist or are emergent in the NHS




### Independent provider contracts

- Separate contracts with individual providers; each responsible for maintaining financial viability.
- Risks allocated to the party deemed most able to manage them.
- No provider captures all gains realised from prevention activities.

### Alliance contract

- One contract with an alliance of parties (informal JV); Collaborative agreement without the need for new organisational forms.
- Collective ownership of risks and distribution of gains; pre-agreed.
- Each party maintains individual responsibility for financial performance.

### Lead contract

- Contract with one provider (e.g. acute, GP Federation) or integrator that then subcontracts with other providers to deliver services in line with commissioner's specifications.
- No direct relationship between commissioner and significant parts of service delivery.
- Lead bears financial risks and benefits.

### Integrated providers

- Health providers across a range of domains (vertical integration) join together into a single entity and contract directly with commissioners.
- Decisions about how best to integrate across services will simultaneously deliver organisational and system value.

### Fully integrated system

- The same entity both pays for and delivers health services.

**C = commissioner P = provider**

**Monitor**

# What is the form?

## There are no legal barriers to commissioning these forms, but contractual mechanisms require CCGs and NHS England to work jointly to derive the full potential benefits

| | |
|---|---|
| **Health and Social Care Act 2012** | Nothing prevents CCGs from commissioning other primary care type services and the intention of the reforms was that the default should be for as much as possible to be commissioned by CCGs. Existing commissioning arrangements provide the flexibility for joint commissioning. |
| **Current commissioning system for primary and community services, and specialised services** | The current commissioning framework does not prevent CCG co-commissioning forms, such as ICOs. Primary medical care is commissioned and funded by NHS England, while CCGs fund and commission community health services. Some community services fall under Local Authority public health including alcohol and drugs services, public health for children and young people, dental public health, screening and immunisations. Only NHS England can enter into GMS, PMS or APMS contracts required for primary care services and it retains the powers to commission enhanced services as part of these agreements. CCGs cannot unilaterally commission services that the SofS has directed NHS England to commission i.e., specialised services, secondary care dental services, prison healthcare etc.<br>CCGs and NHS England can form joint committees to commission and contract these services. |
| **Competition** | Competition typically takes place between existing or potential providers of the same or similar services. The delivery of integrated care requires the coordination of health and social care services across a number of teams from different disciplines, all of whom are responsible for a different component of a patient's care. |

# What is the form?

## There are well understood structural and cultural challenges to implementing these more widely or easily

**There have been a number of early initiatives, pilots and evaluations of integrated care delivery, so key factors are well understood:**

- Traditional organisational boundaries and sovereignty cannot be maintained to the same extent within integrated and accountable forms – this necessitates leaders and management changing mind sets.
- NHS data can be fragmented and is usually not associated with payment. For integrated forms, high quality data available across patient pathways and attached to pricing is necessary.
- To achieve the full potential of the form, population stratification and active management is required. This is challenging without granular data across different service levels.
- Savings driven by one part of the system often equates to a loss of income for providers elsewhere - it is important to structure the contract and pricing correctly to provide incentives for all partner organisations.
- Changes on the commissioner side are also required to enable these forms to emerge more widely to their full potential – separate commissioning, contracting and budgets mean there are few mechanisms or incentives for any single body to take responsibility for patients across all care pathways.
- A lack of understanding or negative perception of competition rules can discourage some organisations and commissioners from exploring these forms.

# What is the form?

## But Monitor guidance suggests competition regulations should not be a barrier to developing integrated care

| | |
|---|---|
| **Competition** | With careful design, many forms for the delivery of integrated care can be implemented in a way that does not reduce competition between providers.<br><br>In most cases, collaboration designed to achieve integrated care is unlikely to raise competition concerns.<br><br>Competition typically takes place between existing or potential providers of the same or similar services. The delivery of integrated care requires the coordination of health and social care services across a number of teams from different disciplines, all of whom are responsible for a different component of a patient's care. |
| **Information governance** | In general, sharing information about a patient's care, including through the use of an integrated IT system, is unlikely to raise competition concerns. Similarly, discussions about arrangements for the transfer of patients from healthcare organisations to social care organisations (or from one healthcare organisation or social care organisation to another) are unlikely to breach the rules on competition. However, organisations should avoid disclosing information that would enable them to align their competitive conduct. Whether or not an exchange of information will have restrictive effects on competition will depend primarily on the characteristics of the information exchanged. |

Monitor (2014). Complying with Monitor's integrated care requirements. https://www.gov.uk/government/publications/integrated-care-how-to-comply-with-monitors-requirements

# Case study

## Case studies for the integrated care organisation form

# Case study

## Ribera Salud, Valencia

- Ribera Salud Grupo was established in 1997 to design, build and operate a new hospital in La Ribera, Valencia Community under a public-private partnership (PPP).
- The Ribera Hospital was the first privately run public hospital in Spain, expanding into primary health services shortly afterwards to strengthen integrated provision following initial strong performance.
- The model has since expanded across Valencia and in other regions in Spain: 4% of the Spanish population is now treated under PPP models, and 20% of Valencia's population.

**Key Learning:**

- The capitated funding model and a "money follows the patient" approach allows for defined public expenditure whilst encouraging quality and efficiency from the provider
- The model is enabled and driven by comprehensive, real time data for management, clinicians and patients to make optimal use of resources

### Governance and Accountability

- Ribera Salud operates the concession under contract with the government, which holds them to account – through a commissioner – for quality standards and outcomes.
- Ribera Salud assumes the risk for demand and outcomes over the 15 year duration of the contract (extendable to 20 years).
- Each hospital is a separate company, with Ribera Salud the majority shareholder in two of these. There are separate governance and accountability structures in each hospital.

### Performance Management

- Variable salary for clinical staff dependent on performance; incentives to actively manage demand and consider wider system aims.
- Strong focus on decreasing clinical variability. Performance metrics are intensively monitored and variation addressed.
- Some staff are directly employed by the local government and cannot be paid the same performance based salary, but these staff are incentivised with training and career pathways.

# Case study

## Ribera Salud, Valencia

### Culture and Values

- The objective of the capitated payment system is "to achieve the best health conditions for the citizen".
- Their business model is to keep all inhabitants within the concession loyal to the organisation, and to keep the population as healthy as possible. Both these are financially rewarded under the contract.
- No company logos – only the national health service branding as in any other public hospital. 94% of patients do not know the hospital is PPP operated.

### Barriers

- The last few years – in difficult wider economic circumstances – have been challenging, as the government is the sole client of the organisation; Ribera Salud is the only European private organisation working solely for the government.
- Implementing the capitated model and aligning the private and public objectives was extremely challenging.
- Requires a new approach of partnership and a long term perspective. There is no short term profit or savings to be made, and a 7.5% cap on return requires a shift in corporate mentality.

### Infrastructure and Central Services

- Ribera Salud financed and built the site, which returned to public ownership after 15 years. They now pay rent to the government for its use (or can reduce protected population and hence income).
- The IT and data systems works across all the sites in the group, providing highly granular data and real time performance feedback.

### Efficiency and standardisation

- There is a strong focus on rationalising clinical and non clinical shared services e.g. single purchasing body.
- In Madrid, Ribera Salud manages a single lab across six hospitals.
- Workforce and expertise is shared between sites in the system, with the same clinicians working in emergency and primary care sites.

# Key considerations

## What are the scenarios in which the form could apply?

Integrated and accountable care forms contain within them a significant diversity of provider configurations, types of provider, contracting mechanisms and populations served. This variation reflects the existing incumbent providers, leadership therein and steps taken to reach the resultant design; there are no specific scenarios in which the form does or does not apply.

There will however be more or less appropriate configurations depending on the area, and in some instances the eventual structure may not be the most suitable for the population and will instead be indicative of historic and cultural reasons.

It is also true in every circumstance that ICOs and ACOs require strong primary and community service provision. Where primary and community service provision is under-developed, acute Trusts can expand services to the community, but this requires significant time and investment. Partnering with new forms of out of hospital provision enables flexible and effective population health management.

## Does the form apply across some or all geographical circumstances?

ICOs are not intrinsically geographically limited, but the geographical circumstance will shape how the form is structured.

- It may be easier to establish the form in isolated geographies where the provider sector is tightly defined and there is little competition for patients.
- In urban areas with unpredictable patient flows, the form is equally applicable but must also contain clear contractual mechanisms and clauses regarding patients from or moving to out-of-area sites.

# Key considerations

## Does the form apply across different health economies?

It is important to remember that integration of providers is not a quick fix to save money; in highly challenged providers, forming an ICO or ACO may be a method to improve patient experience and outcomes, but will not solve short term funding issues.

*Integration costs before it pays* – Leutz

Experience of integration in England has not shown consistent cost savings, and there is usually additional funding required to cover start up costs and establish new ways of working.

In health economies where providers are offering a high standard of care but are currently or expecting to struggle financially, there may be more appropriate solutions to deal with funding issues in the short to medium terms. This does not mean formation of an ICO or ACO should not happen subsequently or concurrently, but this would be to make longer term improvements in outcomes and efficiency rather than to address immediate problems.

Leutz, W. (1999) Five laws for integrating medical and social services: lessons from the United States and the United Kingdom, *Milbank Memorial Fund Quarterly*, 77, 77-110

# Key considerations

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

This archetype by default must include at least both primary and secondary care providers. Although the term is sometimes used to refer to integrated community and acute or social care and acute providers, this is not a true ICO or ACO as it does not include primary care.

The make up of the existing primary care providers in areas moving towards integrated or accountable provision is a key factor. In areas where federations of primary care providers – particularly with multidisciplinary teams within these – already exist, the move to vertically integrated provision is likely to be much easier. Where a disparate network of single practice primary care providers exists, the contracting and negotiations required are much more complex.

# Key considerations

## What is the role of organisational leadership in the form?

ICOs bring together organisations from all service levels, requiring vision and collaboration from all of these.

Organisational interdependence increases significantly with ICO formation; leadership must be willing to surrender a degree of self control. This can be mitigated through contractual mechanisms but a significant element of risk will remain.

As well as provider collaboration, commissioner sign up is ultimately a rate limiting step; incumbent providers must demonstrate strong performance and value to ensure continuing contracts.

To achieve maximum benefit from the form, new models of payment and contracting must be explored by commissioners and providers (capitated, outcomes based payment).

# Key considerations

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

| Interaction with | Applicability |
|---|---|
| Service-level chain | Yes for outreach: an ICO or ACO with specialist expertise in certain areas could offer this service in other organisations as part of a service level chain. They would not be appropriate to host other providers. |
| Multi-service chain | Yes: an ICO or ACO could be one part of a chain i.e. Ribera Salud operates a number of ACOs. |
| Joint venture | Yes: single and multisite Trusts can operate in a joint venture with other organisations (e.g. EOC / Epsom and St Helier). |
| Federation | Yes: ICOs could be involved in a loose federation, particularly those sharing clinical best practice or academic research. They fit less well within federations sharing back office or clinical pathways given the funding and contractual mechanisms. |
| Management contract | Yes: although potentially more challenging than in ownership forms, an ICO could be operated under management contract as at Ribera Salud. |
| Single and multisite Trust | Yes: ICOs would ordinarily by default comprise a single or multisite Trust along with other providers at all service levels in the local area. |

# Key considerations

## Does the form pass the three sense checks?

| | |
|---|---|
| **Does it make sense in the context described?** | Examples from other health systems, alongside emergent and existing initiatives in the NHS suggest the form is applicable to the NHS in England. |
| **Will it make a difference?** | Evidence from integrated and accountable forms abroad alongside the integration evidence base in the UK suggests that there is scope to drive improvements in clinical outcomes, patient experience and provider finances by adopting the form, if developed with rigour and in appropriate contexts. |
| **Is it feasible?** | Although challenging to create full formal ICOs, a number of examples under development alongside international case studies suggests the form is achievable in many health settings in the English NHS. |

# Key considerations

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

### Defensive

- 'Do or die' – allows for rebalancing rather than reducing provider scale to align with prevailing policy direction.
  - Can shift some direct provision into community; less replaced by other providers.
- Mitigate unplanned demand for health services.
  - Collaborative influence over primary and community provision.
  - More strategic control over referrals.

### Strategic

- Opportunity for financial benefit from prevention/early treatment.
- Some potential for economies of scale e.g. back office functions.
- Providing more varied opportunities and career paths for staff, in order to attract and retain the best staff.
- Opportunities to utilise assets and resources across a wider number of sites.
- Well-placed should outcomes based commissioning and capitated or year of life budgets become commonplace

# Key considerations

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

### Technical

- Complex contractual negotiations and drafting.
- Diversion of senior management time.
- Non-compatible IT systems.
- Data availability and granularity.
- Unsuitable infrastructure.
- Unsuitable primary/community premises.
- 50% NHS income cap for FTs.

### Strategic

- Need for commissioner sign up.
- Perception of competition rules.
- Need to align and gain buy in from numerous local delivery partners at all service levels.

# Key considerations

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

### Support

- Spread learning from Integration Pioneers.
- Support from the TDA/Monitor/ CMA to better understand the rules.
- Develop form contracts.
- Develop capitated payment model.
- Myth busting fact sheets.

### Incentives

- Develop and share positive case studies.
- Opportunity that capitated budgets could offer.
- Ability to better manage unplanned care flows.

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