

Future organisational models for the NHS

Perspectives for the Dalton review





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Foreword

Nye Bevan's ambition to 'universalise the best' through the establishment of the NHS may be unfulfilled, but it is as valid today as at the time it was first articulated. Variations in performance among providers are wide and persistent, with some organisations having a long history of financial and service challenges. Few of these organisations may have sunk to the depths of Mid Staffordshire NHS Foundation Trust, but many have struggled to improve their performance despite – or, in some cases, because of – frequent changes in leadership.

In a context in which an increasing number of providers are in deficit and others have been placed in special measures because of concerns about the quality of care they deliver, it is hardly surprising that the search is on for ways of offering them support and raising standards across the board. Sir David Dalton's review of the role of chains of hospitals and services is exploring one particular approach with a focus on how high-performing NHS organisations might lend their support to providers in difficulty. The essays in this report draw on experience within the NHS and outside it, with the aim of providing evidence to inform the work of the Dalton review.

A clear message from these essays is the need to avoid seeking solutions which, in Mencken's time-honoured formulation, are 'simple, elegant and wrong'. As the contributors to this report show, a number of options are available, including buddying successful providers with those in difficulty, franchising the management of NHS hospitals and services to private sector organisations, creating networks and alliances of providers, and enabling high-performing organisations to take over struggling providers. While there is experience to support the use of all of these options in different contexts, much depends on how they are implemented in practice, and there is no evidence as yet that one approach is demonstrably superior to the rest.

Advocating 'horses for courses' may lack the resonance sought by politicians aiming to bring salvation to a troubled NHS, but it is the clear conclusion to be drawn from the work reported here. The impact of different organisational models depends critically on the skills of the leaders involved and their ability to bring



about the changes in culture and behaviour on which sustainable improvements in performance depend. It also hinges on allowing sufficient time for these improvements to be realised, especially in organisations with a lengthy history of performance challenges. Patience, persistence and resilience must be central to this process as leaders engage staff and others in the long march of quality improvement.

To make these points is to argue that strengthening leadership within the NHS holds the key to providing patients with access to high-quality care wherever they live. Leadership needs to be collective and distributed, as important in the frontline teams delivering care as in the boards responsible for running NHS organisations. It needs to be developed across organisations and areas where networks and chains are involved. And there needs to be much greater continuity of leadership in place of the constant chopping and changing that has bedevilled the NHS in recent times. If these insights can be acted on, perhaps Bevan's ambition may eventually be achieved.

Chris Ham

Chief Executive

The King's Fund



Sir David Dalton's review comes at a timely moment as NHS providers reflect on how they should best organise themselves to meet the challenge of continually improving care and meeting rising patient expectations within a severely constrained financial envelope. In fact, there is growing consensus across the sector that providers will need to adapt and design more integrated services around patients. What's also clear is that greater collaboration, co-operation and, where necessary, consolidation between providers will often be part of the solution.

The problem currently faced by providers is the barriers, both perceived and real, to greater and swifter co-operation and collaboration. There is a sense across the NHS that the only provider models available are standalone foundation trusts or trusts, full merger (though this carries regulatory uncertainty) or the sole example of a management franchise.

In fact, as our colleagues in other sectors have shown, there is huge benefit to be derived from using a wider range of organisational models, including federations, joint ventures and networks, and as you look further inside the NHS these models are being used much more frequently than you might think. They're just not particularly well publicised and are often being used at the individual service-line level as opposed to whole organisational level.

I am delighted to have been asked to join the Dalton review expert panel alongside chief executives from a number of Foundation Trust Network members. The review provides a particularly timely opportunity to explore the full range of organisational models that providers could use to meet their current strategic challenges. It's a chance to identify and explore those models; to eliminate the barriers to their wider adoption and identify what providers need to do to implement them effectively. What seems key to me is that providers – in consultation with their communities, partners and commissioners – should be free to choose whatever organisational structure best meets the needs of their local population. We need to avoid the central imposition of a single or uniform solution.

As this publication sets out, there is clearly much that we can learn from existing innovative practice across acute, mental health, community and ambulance settings, from colleagues in the independent and voluntary sectors, and from experiences



internationally and in other industries. I would particularly endorse the conclusion drawn by a number of the articles here – that the skills required to lead different organisational models are often different from those required to run a successful single institution. This reinforces the wider point that the leadership skills required to drive organisational change will become ever more important.

Some believe that moving to different organisational models poses a risk to the future of the foundation trust model. I don't see it that way. The dual concepts of local accountability and earned autonomy from state control that make up the foundation trust model should surely sit at the heart of any provider organisational model.

The diversity of perspectives within this publication bears testament to the vibrancy and complexity of the provider sector. I hope it makes a valuable contribution to the debate on how providers can ensure their clinical and financial sustainability, and to the wider work of the Dalton review team.

Chris Hopson

Chief Executive

Foundation Trust Network



1 Introduction

Candace Imison, Deputy Director of Policy, The King's Fund

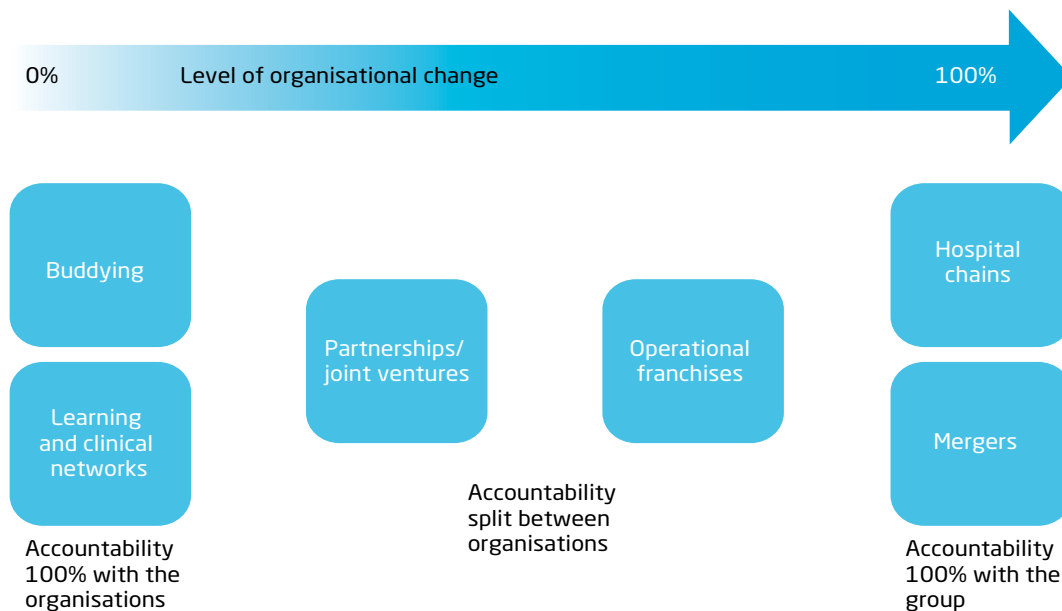
On 14 February 2014, the Secretary of State for Health announced that Sir David Dalton would investigate how to 'enable the best-performing NHS organisations and most successful chief executives to establish national groups of hospitals or services as beacons of excellence' ([Department of Health 2014](#)). The Dalton review will include an exploration of different ways in which high-performing organisations might help those providers in difficulty – including buddying arrangements, franchising, turnaround and the creation of hospital chains. How might new organisational arrangements help drive improvements in struggling NHS organisations and services? Here, we set out some of the organisational options and the evidence, both national and international.

We consider:

- buddying
- learning and clinical networks
- partnerships and joint ventures
- managerial and operational franchises
- hospital mergers
- hospital chains.

One way of framing these options is in terms of the degree of organisational change entailed (*see* Figure 1). At the lowest level, organisations may collaborate without any significant organisational change or ceding of organisational control – good examples being 'buddying' or the development of clinical networks. At the next level, an organisation may lose control over one or more elements of its service portfolio – for example, when a service is outsourced to another organisation or

Figure 1 Organisational options



Source: adapted from Pearson (2011)

moves into a joint venture. Then above that, day-to-day managerial control over an organisation may change – for example, through appointing a franchiser to take over the operational management of a trust. Finally, an organisation may merge or be taken over – for example, by being absorbed in a hospital chain, thus losing total control.

Buddying

One source of support for trusts that have been put into special measures after serious failures in the quality of care is ‘buddying’ with a high-performing ‘partner’ organisation. A partner organisation is selected, by the NHS Trust Development Authority or Monitor, for its strength in the areas of weakness at the trust in special measures. It is too early to tell what impact the current buddying arrangements have had, and any future research will find it hard to disentangle the impact of buddying from the changes in leadership and governance arrangements that are running alongside it. The approach also has some inherent risks. As Ham (2013) has pointed out:

There is also a risk that standards in high performing hospitals may fall if their leaders are distracted by the work involved in helping hospitals in difficulty. An unanswered question is whether leaders who have succeeded in one



organisation can do the same in another, especially where there is a history of poor performance. From this perspective, the impact of partnering may say as much about the leadership of the hospitals providing support as it says about the leadership of the hospitals receiving it, with obvious reputational risks for supporting hospitals if poorly performing ones do not improve.

(Ham 2013, p 347)

However, several of the trusts that have been involved in the buddying process have talked positively about its benefits (Williams and Clover 2014). Dame Julie Moore, Chief Executive at University Hospitals Birmingham, has argued that it is beneficial for staff in challenged trusts to have the opportunity to work alongside those from a larger, more successful trust like University Hospitals Birmingham (Williams 2013).

Learning and clinical networks

The establishment of a 'learning network' provides another means to expose staff in more challenged organisations to the practices and ways of working in higher-performing organisations. Learning networks aim to share best practice and may align policies between institutions, but they do not create new integrated delivery structures. For these loose affiliations to be sustained, they need to demonstrate added value to their participants or they will die (Goodwin *et al* 2004). This provides a salutary warning for the 15 academic health science networks (AHSNs) established by NHS England to 'support knowledge exchange networks to build alliances across internal and external networks and actively share best practice, and provide for rapid evaluation and early adoption of new innovations' (NHS England 2014). As Ovseiko *et al* (2014) have said, 'It also remains to be seen whether AHSNs, which are not partnerships in their own right, can achieve a level of durability that is required to establish them as credible organisations' (p 12). AHSNs are membership organisations, with their core funding coming from NHS England alongside contributions from their members. Membership includes: local authorities; acute, mental health and other NHS trusts; NHS commissioners; primary care providers; higher education institutions; third sector, patient and charity organisations; and industry and commercial partners.

One AHSN that is already demonstrating its value is that associated with UCL Partners. UCL Partners facilitates the improvement of health care through a range of clinical and academic designated roles, including the AHSN, an academic health



science centre and an education lead provider. It is also aligned with a National Institute for Health Research (NIHR) Collaboration for Leadership in Applied Health Research and Care, and an NIHR Clinical Research Network. Bringing these roles together appears to have not only maximised the potential synergies between education, research and service, but created a critical mass of resource that has allowed the AHSN to make real headway in its core priority areas. A good example is its work on dementia: the AHSN is not only driving forward an ambitious research programme, but has provided dementia awareness-raising training to more than 12,000 staff ([UCL Partners 2014](#)).

The establishment of hospital and managed clinical networks provides examples of a more formalised network structure, also with the aim of driving improvement in the quality of care and more cost-effective deployment of resources. These arrangements often receive financial support for network development, but participating organisations retain full organisational autonomy, even though commissioning decisions may alter the profile of clinical services. Good examples are the development of stroke, cardiac and cancer networks. Historically, the development of clinical networks was led by strategic health authorities, now reconfigured as 'strategic clinical networks', which are funded and managed by NHS England ([NHS England 2012](#)). While there is evidence of the quality benefits that these arrangements can bring, they are often hard won (Greene *et al* 2009; Hamilton *et al* 2005; Morris *et al* 2008). As Goodwin *et al* (2004, p 344) described:

... there is a constant tension between the network's need to establish its own identity and with the individualistic tendencies of hospitals, indeed clinicians within hospitals, concerned with their own interests... Co-ordinated hospital and clinical networks appear to also stress the importance of some kind of joint clinical governance framework to tie together roles and responsibilities and achieve 'operational excellence'.

Partnerships and joint ventures

Hospital partnerships or joint ventures may operate through relatively straightforward contractual arrangements whereby one partner undertakes to deliver a specific service to the other. A good example would be the model developed by Moorfields Eye Hospital NHS Foundation Trust, one of the world's leading eye hospitals, under which they offer a range of specialist and routine



ophthalmology services through satellite clinics in hospitals across London and elsewhere. The network is run on a matrix system, with each unit headed by a lead nurse as well as a lead clinician (Mooney 2008). The receiving hospital benefits from Moorfields' specialist expertise, while Moorfields benefits from the larger revenue base. There has been no formal evaluation of the Moorfields model, but its continued growth is one marker of success.

These partnerships may also incorporate a greater degree of collaboration and risk sharing, as demonstrated by the elective orthopaedic service in south-west London. The Elective Orthopaedic Centre (EOC) is operated through a partnership between St George's Healthcare NHS Trust, Croydon Health Services NHS Trust, Kingston Hospital NHS Foundation Trust, and Epsom and St Helier University Hospitals NHS Trust. The EOC is overseen by a partnership board with representation from each of the four trusts, which are also party to a financial risk-sharing agreement. The EOC is staffed primarily by surgeons from the four host trusts and is now one of the largest hip and knee replacement centres in Europe. It has won awards for the quality of its services. Interestingly, the EOC benefited at its inception from a budding relationship with the Hospital for Special Surgery (HSS) in New York. The HSS is a world leader in orthopaedics, rheumatology and rehabilitation. The HSS worked with the EOC to replicate its patient-focused system of care by transferring its quality models of infection control, patient education, and patient 'throughput' and rehabilitation protocols. After instituting HSS's best practices, the EOC saw a significant reduction in costs, improved outcomes and increased patient satisfaction ([Hospital for Special Surgery 2004](#)).

The evidence suggests that effective partnerships and joint ventures are (not surprisingly) dependent on the quality of the working relationships between the organisations involved. These relationships appear to be facilitated by more decentralised management structures and effective performance management (Hackett 1996). Joint ventures do not involve any change in ownership of the host organisation and can be perceived as a 'win-win' solution for the organisations involved. A key issue for these types of arrangements is to ensure that the appropriate governance model is in place to manage the shared financial and clinical risk, with clarity about lines of accountability. The arrangements in south-west London have just had to be revised to create more robust governance, including greater clarity about how costs are to be recharged between the partners ([Kingston Hospital NHS Foundation Trust 2014](#)).



Hospital franchises

The NHS has used both management and operating franchises as a means to improve the financial and clinical performance of a failing provider. Under a management franchise, the franchisee takes over the management of a trust for an agreed period of time. Management franchises aim to address leadership deficits in a trust through the introduction of a new chief executive or management team from either the NHS or the private sector. Under an operating franchise, the franchisee – which may be an NHS or private sector organisation – takes on day-to-day responsibility for both the operation and finances of the trust for a set period of time (*see also* the contribution from David Hamlett, of Wragge Lawrence Graham, p 50). Some see a franchise as a means to secure access to a management team's expertise and capacity without the downsides of merger ([Malby et al 2014](#)). Others have highlighted the opportunity to use a franchise agreement to secure desired improvements in quality and efficiency ([Pearson 2011](#)). The model is also scalable, as a franchiser can hold the operating licences to two or more trusts. [Malby et al \(2014\)](#) also highlighted the potential disadvantages.

It is not always easy to develop a 'manual' and control quality at a distance from the parent organisation and tensions between the entrepreneurial franchisee and the franchisor can go both ways – the franchisee can add ideas or it can be seen as trouble. There are some factors to balance and boundaries must be managed in order to make the model work for all parties.

There is one significant tension built into the model that is critical for the NHS if it is to develop more franchised services. Tension often forms between the franchisor's business model, which is built on standardisation, and the desire in the franchisee to achieve its own identity and 'personalisation' in the sense of a community service.

This tension is very apparent in commercial forms of franchise (Sorenson and Sørensen 2001). Sorenson and Sørensen talk about two different types of organisational learning, 'exploitation' and 'exploration'. Exploitation helps the franchiser or chain owner (*see* the section on hospital chains, p 15) realise economies of scale and consistency through the application of standardised practices across all units. On the other hand, exploration supports the development of new routines to capitalise on novel environmental conditions. The challenge within these arrangements is to support and balance both forms of learning.



The NHS has relatively limited experience of both managerial and operational franchises. In 2003, the Department of Health (2003, p 7) offered up a management franchise for any poorly performing (ie, zero star) trust that did not demonstrate capacity to improve performance. The franchise for Good Hope Hospital was awarded to a private provider, Tribal Secta, representing the only external management franchise of its kind at the time. The contract was terminated after two years because the arrangement was no longer considered financially viable, with the hospital incurring an increasing deficit. Instead, the management franchise was taken over by the neighbouring Heart of England NHS Foundation Trust, and the hospital was ultimately acquired completely.

The NHS has only one example of an operating franchise for an entire hospital, the franchise agreement with Circle to manage Hinchingsbrooke Health Care NHS Trust. The improvements in clinical and financial performance at Hinchingsbrooke since Circle took over give some grounds for optimism (*see* the contribution from Steve Melton, Chief Executive of Circle, p 38).

Hospital mergers

Trust merger has, for many years, been the default option to address financial failure in the NHS. The majority of the 112 NHS mergers between 1997 and 2006 involved at least one hospital that was performing poorly financially (Gaynor *et al* 2012).

Mergers in health care are expected to bring economic, clinical and political gains (Fulop *et al* 2005). Economic gains are expected from economies of scale and scope, particularly through reductions in management costs and the capacity to rationalise provision. Yet mergers frequently fail to achieve their stated objectives. Some estimate that up to 70 per cent of mergers have failed to add value (KPMG 2011). Gaynor *et al* (2012) observed no productivity improvements in 102 of the 112 acute hospital mergers between 1997 and 2006, and no improvement in financial position. But while mergers offer theoretical opportunities to lower costs by achieving economies of scale, several studies have noted that health care mergers often raise costs (Vogt *et al* 2006; Kjekshus and Hagen 2007). As Burns and Pauly (2002) noted, 'economies of scale do not automatically flow from hospital size and merger' (p 132).

Clinical quality improvements are regularly stated drivers for hospital merger (Fulop *et al* 2005); however, there is a lack of conclusive evidence that mergers alone have



a positive impact on clinical outcomes, and there is some evidence of reductions in quality as a result of merger (Fulop *et al* 2002; Fulop *et al* 2005; Gaynor *et al* 2012; Ho and Hamilton 2000). The literature across all sectors highlights risks to organisational performance as a result of a merger (Dranove and Lindrooth 2003; Spang *et al* 2001; DiGeorgio 2003; Christensen *et al* 2011; Sirower 1997; Chen and Gayle 2013). In health care, there is a risk of managerial attention turning inwards, and focusing on issues such as restructuring rather than core service delivery (Fulop *et al* 2012).

Dranove and others have argued that to fully realise benefits, a focus on wider clinical reconfiguration is required (Dranove and Lindrooth 2003; Dranove 1998; Kjekshus and Hagen 2007). Sloan *et al* (2003) argue that the most successful health care consolidations (in terms of cost savings) have occurred when one or more facility is closed and virtually all inpatient services are provided on one site. Yet achieving this type of change in the NHS frequently generates public and political opposition and can take many years to achieve (Imison 2011).

A common issue in failed mergers is a decision to merge taken at speed without sufficient clarity as to what the key objectives were or how they were to be achieved (Sirower 1997; Epstein 2005). Merged organisations frequently seek to realise new efficiencies through integrated systems functions and procedures. However, both Gerds *et al* (2010) and Fletcher (2008) found that core business processes and their interdependencies are often not systematically thought through. A lack of cultural integration can also be a significant barrier to a successful outcome from merger in all sectors (Pikula 1999; Kanter 2009; Blackstone and Fuhr 2003). Cultural issues are particularly important in health care because of the complex dynamics at play within and between different professional groups (Braithwaite *et al* 2005; Fulop *et al* 2002).

Mergers need to have clear and quantifiable objectives with a clear road map as to how they will be achieved. Addressing issues of culture and communication is also critical. The importance of clinical engagement in health care organisations is well documented (Ham and Dickinson 2008). The full benefits of mergers are unlikely to be met without effective clinical integration (Fulop *et al* 2005; Corrigan *et al* 2012).



Hospital chains

One step beyond hospital merger is the consolidation of hospitals into large hospital chains, a consolidation that is better characterised as an acquisition rather than a merger. In the United States, there has been a longstanding trend for both non-profit and for-profit hospitals to be taken over to form hospital chains.

In 2011, 60 per cent of US hospitals were in a hospital chain, with 3.2 hospitals per chain on average (Cutler and Scott Morton 2013). There are also some very large US hospital chains in both the for-profit and non-profit sectors, including a significant number of chains with more than 50 hospitals. Examples include: the Hospital Corporation of America (for profit), with more than 160 hospitals; Ascension Health (non-profit), with more than 100 hospitals (Dunn and Becker 2013); and Tenet, with more than 70 hospitals (*see* the contribution from Brad Stoltz, Chief of Staff at Tenet Healthcare Corporation, p 19). While public hospitals in America have also formed chains, they have not grown at the rate of the for-profit and non-profit chains (Cuellar and Gertler 2003). It is important to note that US hospitals are, on average, considerably smaller than those in England and serve much smaller populations. Half of the community hospitals (the US equivalent of the district general hospital) have fewer than 100 beds (American Hospital Association 2011).

In general, large multi-hospital chains in the United States have not had a positive outcome for the consumer (Cuellar and Gertler 2005). There is strong evidence that hospital consolidation in the United States has driven up hospital prices as providers have increased their market power (Berenson *et al* 2012; Melnick and Keeler 2007), the effect being greater where hospitals are geographically closer (Vogt *et al* 2006; Cutler and Scott Morton 2013). In addition, consolidation has not released significant cost savings unless providers have consolidated their services onto a smaller number of hospital sites (Vogt *et al* 2006). In the United States, low occupancy levels (less than 55 per cent) make this rationalisation cheaper and easier (Connor *et al* 1997). Some have argued that consolidation can drive up rather than reduce costs (Cuellar and Gertler 2005; Dranove *et al* 1996), especially if there is additional investment in estate and infrastructure. Many hospitals were offered up for acquisition because they could not access the capital resources necessary to grow and compete with other providers (Blumenthal and Weissman 2000).

The evidence on the impact of consolidation on quality is also mixed. In some studies of the direct effect of hospital market concentration on the quality of care,



some have found a negative impact for at least some procedures, some a positive impact and some no impact at all (Vogt *et al* 2006). There are also examples of the chain's corporate objectives overriding clinical ones, and clinical quality being threatened (Creswell and Abelson 2014).

The experience in Germany is more promising. One chain, Helios (www.helios-international.com), has been able to demonstrate reductions in in-hospital mortality in hospitals that it purchased (Nimptsch and Mansky 2013). Helios immediately integrated the hospitals it took over into its quality management system, which relies on three principles: regular monitoring of quality indicators; reporting the results to the public; and analysing and improving treatment processes through peer review. Each hospital's performance is regularly measured and benchmarked using a wide array of quality and outcome indicators. Any 'subpar' results trigger a peer review with a view to improving the hospital's treatment processes – for example, by better adherence to guidelines, better and more narrowly targeted workflows or improved interdisciplinary teamwork. The system is overseen by the physicians on the Helios Medical Advisory Board, who are also charged with the medical integration of new hospitals into the Helios Group.

The positive experience at Helios chimes with evidence from a major study of health systems (including hospital chains) in the United States (Yonek *et al* 2010). This showed that there was no one system type or system factor linked to high performance. High-quality scores were achieved by a variety of system types – large or small systems, geographically regional or multi-regional systems, systems from all regions of the United States and systems with different levels of teaching components. More than 50 system factors that might distinguish between high- and low-performing systems were investigated and none clearly correlated with high performance. This mirrored the findings of a study of Massachusetts providers, which concluded that 'no single type of provider organisation performs consistently better on measures of quality or efficiency and no single type of provider organisation is better positioned to deliver coordinated patient care' (Office of the Massachusetts Attorney General Martha Coakley 2011, p 39).

The key drivers of success identified in the Yonek study (Yonek *et al* 2010) are a culture of performance excellence, accountability for results and leadership execution (*see box*). The lack of a uniform culture across hospitals, internal



Key features of high-performing health systems

- Shared, system-wide commitment/focus on achieving the system's quality and patient safety goals.
- A system board that sets the strategic goals for quality and safety and frequently monitors progress towards achieving those goals.
- Extensive opportunities and vehicles for hospitals to collaborate and share best practices for improving quality and safety.
- Transparency around reporting performance, both internally and externally.
- Emphasis on the importance of teamwork to improve quality and safety and shared accountability for good outcomes.
- Having a mindset of perfect care and dramatic increases or stretch goals as compared to incremental improvement.

Source: [Yonek et al 2010](#)

resistance to culture change and the absence of leadership commitment all created barriers to improvement.

These findings resonate with earlier findings on high-performing health systems by Baker *et al* (2008) and transformational change in health care systems (Lukas *et al* 2007).

The quality of leadership execution will be critical. The current leaders of successful NHS organisations have had limited opportunities to work across wide geographies and within a 'group' management model. The tension between what is done centrally versus locally, and between supporting consistency versus the capacity to innovate, are key issues for any chain or group model. Managing this tension will be new territory for many NHS chief executives.

Conclusion

The evidence suggests that most of the organisational arrangements we have described could help drive improvements in the quality of NHS services. Some have



argued that the benefits delivered from health care organisation collaboration are commensurate with the level of organisational change (Pearson 2011). However, the evidence suggests that the higher the degree of organisational change, the higher the risk that the benefits will not be delivered. The evidence on mergers and acquisitions is pretty unequivocal that the risks from full-scale organisational change are high. While there are examples of successful chains, in general the evidence suggests that this model also carries significant risks.

The common success factors across all the different models are good working relationships and a strong, common focus on quality improvement, with measurable means of achieving that improvement. And, as Ham (2013) has argued, there must be a focus on changing the culture that gave rise to poor performance in the hospitals needing help.

The factors that will deliver economic benefits from these new relationships are harder to draw out. The evidence from the United States and hospital chains suggests that the greatest savings opportunities arise from situations where the partnership facilitates the removal of redundant or duplicated capacity. There are clearly opportunities too from the partnerships facilitating process redesign and efficiency savings. In any model that involves organisational integration, there will also be a need to balance the two different types of organisational learning described by Sorenson and Sørensen (2001) – ‘exploitation’, to maximise economies of scale, and ‘exploration’, to foster innovation.

Finally, there is a growing body of opinion that a trust’s problems cannot be solved in isolation. Wider systemic problems, shifts in policy, the legacy of complex financial relationships (such as private finance initiatives) and the viability of clinical service models will require a whole system solution and perspective (Public Accounts Committee 2013, p 10). Any solution needs to recognise this broader perspective.



2 Brad Stoltz

Chief of Staff, Hospital Operations, Tenet Healthcare Corporation

Tenet Healthcare is a large, investor-owned US multi-hospital system with an annual revenue/turnover of about US\$16 billion. Tenet owns and operates 77 acute care hospitals across the United States as well as a range of other health care facilities, including more than 190 ambulatory care facilities. The primary areas of operation are California, Michigan, Texas, and Florida, with smaller operations primarily in metropolitan areas such as Boston, Philadelphia, Phoenix, Atlanta, Chicago, Memphis, Charlotte, and St Louis. Tenet also owns Conifer Health Solutions. This subsidiary provides services to other health systems, predominantly IT and back office solutions to support revenue cycle operations and patient access, as well as population health management services.

Operating as a large, multi-hospital system has a number of obvious benefits (and some less obvious benefits) compared to operating as an individual hospital. The biggest benefit for a system such as Tenet is to make investments that single hospitals or very small chains cannot afford to make. For example, we are able to invest in technology and systems to support clinical operations and quality, as well as labor management, billing/collection, and patient communication. There are other areas that lend themselves to scale, such as purchasing, operations improvement systems, and deep operational expertise.

On a larger scale, our geographic spread and size enable us to spot and spread new ways of delivering services. When we see something happen in California, we have the ability to translate lessons to other geographies across the country. One of the areas in which we've been fairly active and successful has been the development of our ambulatory or outpatient platform. Many US-based health systems rely on third parties to assist them in developing their ambulatory strategy and then managing outpatient activities. Having identified the importance of these types of facilities in certain geographies, we chose to create the capabilities to develop and manage them internally within Tenet. Therefore, we could quickly build or acquire these types of facilities in other communities, and then increase their value through integration with the rest of our health system.



Vertical integration is certainly one element of our strategy, owning more of the patient care continuum so that we can deliver more integrated care. Our system affords the scale to develop a physician practice management organization that operates nationally. We employ 1,800 physicians across the country and are aligned in many different ways with thousands of additional physicians on our facilities' medical staffs.

We see particular benefits in geographic areas in which we have a high density of facilities and can appropriately co-ordinate activities and services. In situations such as these, we can better co-ordinate services – we can invest in developing distinctive services in one facility while offering more basic services in the other facilities within that geography. Our best example is in south Florida, where we've got 10 hospitals across 3 counties (total population of 5.8 million across these three counties), and have made significant efforts to develop co-ordinated neurosciences and cardiovascular networks across these three counties. With our neurosciences program, we have configured our stroke services to establish four comprehensive stroke centers and six primary stroke centers across our footprint. All facilities operate under similar clinical protocols, monitor similar clinical quality metrics and reporting elements, and can share clinical data when patients use different facilities. The primary stroke centers provide care for patients not requiring comprehensive services. If a stroke patient requires comprehensive stroke care, then the primary center is quick to transfer the patient to one of the comprehensive stroke centers. This is an example of a system's ability to co-ordinate and deliver top-quality care across a geographic area.

Generally, in the US market, there is not that level of co-ordination between hospitals. Most hospitals want to service as many patients as possible, which can lead to redundant investment and sub-scale volumes to achieve operational and clinical efficiency in higher acuity service lines. Another benefit of scale is that if you develop a first-class service-line program in one market, you can rapidly apply that program in another market. Within Tenet, we are in the process of implementing similar stroke programs in other geographies.

On the clinical side, there is also a clear advantage to operating off a larger platform. Over the past four to five years, we have installed an Electronic Medical Record (EMR) system across all our facilities. Because of our system's size, we have been able to invest in the analytical capacity to harness that clinical data and use it to identify the best



clinical and operational practices. If we come up with an example of a good practice in one facility, it's fairly easy for us to roll that out across our system.

We can also develop our clinical systems to be more intelligent and to help clinicians improve care. A good example is a clinical protocol we have implemented to mitigate sepsis. We have deployed algorithms within our EMR system that trigger an alert whenever a patient starts showing potential early indicators of sepsis, which enables the physician to take a closer look at that patient.

There are certain elements of Tenet's culture that are important and non-negotiable – for example, the focus on clinical quality. There's a real focus on doing business the right way and being compliant with applicable laws and regulations. Once you get beyond those two guard rails, there is a lot of flexibility for our hospitals to dictate how they meet the needs of their communities. When acquiring new hospitals, we purposefully retain many of the elements of the existing hospital culture. For example, if the hospital has historically had a faith-based affiliation, after acquiring the facility we will sustain that focus on meeting patients' spiritual needs when receiving care.

We do not employ most of the physicians who practice in our hospitals; therefore we need a collaborative approach in working with physicians in our local facilities. Very often we'll have a physician leader – either a chief medical officer or a service-line medical director – as well as several formal physician councils or physician leadership groups within our facilities. These individuals or councils are charged with supporting hospital leadership by having those physician-to-physician conversations to discuss the clinical evidence and explain why hospital leadership is suggesting that they move from this product to that product (or from this clinical protocol to that clinical protocol). We have a number of multi-facility or system-wide clinical councils, some of which have a geographic focus and some of which have a service-line focus.

We have three groups that help drive operational and clinical improvement across our system. The first group is a performance management and innovation group that's very operations focused. Historically, this group has looked at standardizing operational practices and implementing cost-control efforts across the system. That group has done a lot of work in standardizing medical devices and implants, pharmaceuticals, and other service providers, more from a contracting perspective



as opposed to a clinical perspective. We also have a physician-led clinical operations group. This group has historically focused on monitoring and improving clinical quality and patient safety across the system, as well as driving policy in areas that fall within the clinical realm. The third group is newer – our applied clinical informatics group. They sit within the IT function and over the past three to four years have been charged with rolling out our EMR system. However, now their focus is transitioning toward realizing the clinical and operational benefits from the investment we have made in EMR systems.

We have now brought these three groups together through our performance excellence program. Performance excellence is a cross-functional, multidisciplinary approach to increasing the value we deliver to patients, payers, and health care providers. Performance excellence has only recently been enabled because of the wealth of data that's now available to us through our EMR systems. Health care is infinitely more complex than any factory process. Applying a discipline that views it from these different perspectives is really essential to improving the way that patients receive care in our hospitals going forward.

We are also rolling out lean daily management techniques across the whole of Tenet. Interestingly, this was triggered by one of our recent acquisitions, which had already adopted this approach. We think conceptually it's the right thing to do – to empower our employees to solve issues and drive improvement at the appropriate level within the organization. There will be tremendous benefits from this program, and we have already seen early evidence of these benefits. The biggest challenge is shifting people's mindsets if they have not previously worked in a 'lean' environment. This is a much harder task than bringing someone in from day one and saying 'this is just the way it's done here.'

When deciding whether to acquire a new hospital or hospitals, we take a number of things into account. Any facility we acquire has to be relevant and appropriate in its community. In some markets here in the United States, you see too many hospitals generating excess capacity relative to what the community really needs. This presents a situation where – even if we acquire a hospital in that community and bring it onto our platform – we can still only help so much; we can't change the conditions within the market. The second critical factor is the pre-existing culture of the hospital. If the starting point from a cultural standpoint is too low – not focused



enough on quality and compliance – then we are not likely to be interested because ultimately the reputation of our entire system is at stake.

We are more attracted to potential acquisitions or joint ventures in which we can add incremental value to a quality operation that could benefit from our system-wide capabilities. For example, if a facility is in an area adjacent to one of our facilities, then we can naturally expand what we're already successfully doing into a new community. Another attractive situation is when we have the opportunity to acquire a reputable facility with high-quality physicians. By adding the hospital onto our national platform, we are able to help them both move to a higher level of performance.

This is a very complex time, given the changes that are going on within the health care industry. For the leadership of a standalone hospital, it must be incredibly difficult to address simultaneously the new challenges facing our industry – preparing to manage population health and enter into risk-based contracts; implementing state-of-the-art EMR systems, expanding vertically into ambulatory and post-acute care settings – while still executing traditional activities such as managing workforce, building service lines and controlling costs. The largest source of value for having scale is that you have dedicated individuals, teams, or functions that can focus on how to address these issues system-wide. Then hospital leaders can contribute their own ideas about how to implement solutions to address these challenges, but with an eye toward delivering health care that meets the particular needs of the community. The value of being part of a larger chain is that you don't have to solve everything yourself. You're not in it by yourself, you're in it together, so you can come up with a better solution and a better approach by pooling resources and thinking collectively.



3 Jonathon Fagge

Chief Executive, Norwich Clinical Commissioning Group

Jonathon originally qualified as a barrister in 1995, and then joined the pharmaceutical industry, working across licensing, marketing, finance, legal and compliance. He left the industry in 2001 to set up a consultancy firm, and worked with NHS customers across the East of England – general practice, NHS providers and primary care trusts. In 2010, Jonathon joined Norwich Practice-Based Commissioning Group, and managed the transition to a clinical commissioning group (CCG). He was appointed Chief Executive Officer in August 2012.

NHS Norwich CCG serves a city and suburban population of just over 210,000. It is a clinically led commissioning organisation with a budget of £220 million per annum.

I have been reliably informed that hospital chains are a dreadful idea.

They are ideologically motivated by a political mainstream that places too much faith in markets. It is an ill-considered policy dreamed up by theorists who have no idea how hospitals actually function. It will concentrate power in a small number of big acute brands and confound the main thrust of NHS reform to treat fewer patients in hospital. It places too much faith in heroic leadership, when the success of any hospital derives from a complex interplay of people, geography, population size, competitive environment, workforce availability, input costs and competent commissioning. These factors cannot be replicated by putting your brand over a different door.

But this analysis begs a question. If the chain model – the duplication of a product and service offer to different geographical markets under a recognised brand – is so problematic, why does it dominate almost every consumer-facing industry, and how has it established itself in state-supported health care across Europe, India and the United States?

The fundamental challenge for the NHS is no different from any other industry – how to deliver total quality. The financial challenge, the demographic shift in



demand, the thankfully rare but deeply shocking failures in compassion and care, and the gap between public expectations and the current offer all ultimately pose the same question. How do we deliver health care that consistently meets the needs and expectations of consumers while reducing costs at the same time? The answer is simple to describe, is difficult to achieve and is the battleground on which market share is won and lost, and brands rise and fall.

First, you make the effort to understand what your consumers really consider important. Then, you work out the most cost-efficient way of delivering it and consistently apply that delivery method right across the organisation. Finally, you constantly look for new ways of delighting the customer or reducing waste, and disperse those new ways through the organisation as quickly as possible. The best brands understand the Six Sigma mantra that variation is the true enemy of quality, of efficiency and of customer satisfaction. You determine the optimum way of delivering a product or service and you make everyone deliver that way. By doing so, you make quality more consistent, more predictable, better understood and cheaper to deliver.

Let us suppose for a moment that our very best hospitals reach the top of the pile because they pursue and systematise quality. They eliminate drug errors through a safe, standard and efficient process that everyone follows. The range of drugs, prosthetic joints, dressings, anaesthetics and cleaning products has been rationalised, reducing complexity and error, and increasing the volume of those they still use to increase purchasing power. Their admission and discharge processes have been streamlined to reduce average length of stay, increase bed utilisation and end the frustration for patients who want to get home. In a hundred different ways they have standardised their clinical, administrative and managerial behaviours; and by doing so, patients experience shorter waits, greater convenience and better outcomes, and are no longer subject to a haphazard, repetitive and indifferent bureaucracy. Every month they introduce changes to further improve quality, implemented quickly and comprehensively by every staff member. They have become a recognised and trusted brand, rightly associated with high-quality, harm-free, convenient and compassionate care.

This supposition may be wrong – it may instead be a mix of favourable environment, a stable financial legacy and a few charismatic champions. But if they have been pursuing quality as a systematic goal, and excellence across the organisation, then



this is not only a strong foundation for continued success, it is mobile, and can be replicated in every link of a new hospital chain.

Hospital managers would have to acquire a new set of skills from retail, or hospitality, or global logistics, in order to open a new branch on the other side of the country and make it work in just the same way as the flagship store. They would have to make sure that innovation flows in a fast but controlled system. And they would have to convince a sceptical workforce that this is the answer, that the effort of change is worthwhile and that if they participate, they can be architects as well as builders of a successful and trusted brand.

Most patients believe that a national chain already exists – the NHS brand adorns every front door, uniform and letterhead. They are bemused and sometimes harmed by its variation and fragmentation, and I suspect they would wonder why we allowed it to be broken up in the name of markets, competition and choice.



4 Dr Nick Marsden

Chairman, Salisbury NHS Foundation Trust

Nick joined Salisbury NHS Foundation Trust as Chairman on 1 January 2014.

Prior to joining Salisbury, he held the position of Deputy Chair and Senior Independent Director at University Hospital Southampton NHS Foundation Trust. He held various non-executive positions in this organisation over a six-year period, during which time it achieved foundation trust status.

Prior to joining the NHS, Nick spent 30 years working in the IT industry, principally with IBM, occupying several board-level positions in various UK and European organisations. He has led groups of more than 2,000 people and been responsible for delivering revenues in excess of £1 billion.

The concept of management chains, including franchises and different organisational forms, has the potential to work, but (like most business decisions) it depends fundamentally on what we're trying to achieve. I have both operated within and led management chain-type concepts in my commercial life.

If the 'chains' concept is a way of saying that we can produce a management blueprint that is replicable over a number of organisations, that understands the key elements of those organisations and how it is going to replicate a common management culture, set of methods and priorities across several diverse organisational environments and local cultures, then it can probably be made to work.

But from the outset, we have to understand why we're considering pursuing this approach. Is it in order to guarantee more consistent delivery of service quality? Is it about improving the culture of more challenged organisations?

We need to be really clear what our initial objectives are. Next, we need to have a confident and well-founded view that this method will work in a number of very different environments.



Like any innovation, the concept of management chains presents a range of potential challenges and opportunities. One of the biggest challenges I can see would be to maintain the uniqueness of a trust such as Salisbury – for our organisation, for our community and for our patients.

Our organisation is a hybrid: on the one hand a strongly community-based and indeed community-embedded district general hospital (DGH), and on the other a provider of specialised services across a much wider geography. We provide the services with outstanding clinical outcomes and patient experience while maintaining a positive financial balance. If we were part of a chain of franchises, would the leaders and managers of that chain understand our ‘Salisbury-ness’ and how our internal linkages lead to such performance?

One significant reason why this organisation has been so successful is that we take our basis in the local community very seriously. Anything proposed that’s to do with management chains and that kind of business-speak would probably make our management locally and our community feel very nervous indeed. So we’d need to really clarify how we preserve that important sense of being firmly rooted in and answerable to our locality, while also getting whatever benefits a chain approach could provide.

The governance arrangements around chairs, non-executive directors and boards needn’t be a major issue. There should be no reason why a well-led, well-functioning non-executive board couldn’t look after several organisations rather than one from a high-level business perspective.

The governance issues would be very much around the role of governors of foundation trusts, representing patients and community. How could they represent these constituencies as effectively if they’re expected to govern for a management chain operating across big cities, coastal towns and large conurbations? How would the views of local people in Salisbury be represented? Is there sufficient bandwidth in governors’ ability to scrutinise? Our non-executive directors are very much embedded into both our local community and the operation of our hospital. Would that still be the case in a large chain or franchise?

The circumstances in which a management chain or franchise might be workable in the NHS are probably more in areas of specialisation – where it’s a case of providing



a very specific service, as Moorfields has successfully done with its brand for all kinds of eye care. The concept might not be a good fit for our kind of district general hospital because of the ‘D’ and the ‘G’ in ‘DGH’. The point about a successful DGH is that it is customised to its locality and patients; and for those DGH providers who are not locally focused and customised, this is probably a big part of why they are challenged or troubled – if they’re not appealing to their local population, they won’t enjoy its support.

Like many of the improvements to the structure of the NHS that are being proposed at present, management chains could be effective given the right circumstances. My nervousness is because they are always seen as a panacea to all problems without a sensible analysis of how and whether they can apply in the sensible local circumstances.



5 Sir Michael Deegan

Chief Executive, Central Manchester University Hospitals
NHS Foundation Trust

Sir Michael Deegan has been Chief Executive of Central Manchester University Hospitals NHS Foundation Trust (CMFT) since 2001. Among his achievements, he has: led the trust through a successful merger, upon its establishment; overseen the £520 million private finance initiative redevelopment of its Oxford Road campus; attained, in partnership with the University of Manchester, Biomedical Research Centre designation in 2008; and managed the transition to foundation trust status with effect from January 2009. The foundation trust is also the first NHS lead sponsor of a groundbreaking Academy for Health, Bioscience and Sport, which opened in September 2009. CMFT is a founding member of the Manchester Academic Health Science Centre, one of only five such centres designated across the United Kingdom. In April 2012, CMFT undertook the formal acquisition of Trafford Healthcare NHS Trust.

Central Manchester University Hospitals NHS Foundation Trust (CMFT) is a large and complex hospital group that draws patients from Greater Manchester, the north west and beyond. We have a wide range of clinical services ranging from local hospital and community care through to specialist tertiary functions, and we have extensive teaching and research commitments. Prior to 2012, the hospitals in the group included Manchester Royal Infirmary, Saint Mary's Hospital (women's services), Manchester Royal Eye Hospital, Royal Manchester Children's Hospital and the University Dental Hospital of Manchester. On 1 April 2012 we took over the hospitals that were previously under the management of Trafford Healthcare NHS Trust. These included Trafford General, Altrincham General and Stretford Memorial. We now have a turnover of around £950 million and capacity in excess of 1,200 beds, and we employ more than 13,000 staff. Our experience provides one model of how incorporation into a hospital group or chain can help a trust that is struggling to create a viable future on its own. But I should stress that this is just one of a spectrum of organisational models, including buddying, partnerships and joint ventures, which Sir David may be considering as part of his review. For other organisations, in different settings, these models may provide a better solution.



CMFT has a well-established group structure in which the board sets the overall corporate direction, but the vast majority of what we do is devolved down to the individual hospitals. Organisational subsidiarity is one of our defining principles. We make sure decisions are made as close as possible to the patient. However, our scale enables us to look in a more determined way at the support and back-office functions to ensure that we drive efficiency between and across our hospitals. The governance and performance of each of the hospitals within the group is assessed in the same way as the whole organisation is as a foundation trust.

Each hospital is led by a clinical head of division – an experienced senior consultant who has been through all our internal leadership programmes – and each is supported by a hospital director who operates at a level equivalent to an executive director in a mid-sized organisation. We have bespoke human resources, finance, service development and quality teams in each of our hospitals. So, when we acquired Trafford, it dropped relatively easily into our overall leadership arrangements.

The Trafford Healthcare NHS Trust operated traditional district general hospital services from facilities located around seven miles from our main Manchester Royal Infirmary site. When we took it over, it had an underlying recurrent deficit of £19 million per annum, which was continuing to grow. Also, some services simply were not seeing sufficient numbers of patients to allow the teams to maintain their clinical competencies, and in certain areas there were difficulties in recruiting and retaining staff with the right skills. As such, there were growing concerns about the clinical sustainability of some services. Our motivation to take on Trafford was twofold: first, as a board, we didn't want a hospital that was close to us to end up with a series of unplanned changes and patient flows that could threaten our ability to deliver to the rest of our agenda; second, we felt strongly that all NHS organisations need to consider their own system leadership responsibilities and that we should support a neighbouring organisation that had recognised it was unsustainable on its own.

CMFT acquired Trafford after a restricted procurement process. Our first task was organisational integration, including a full back-office merger. This was completed by October 2012. We then developed a new service model that went to full public consultation and, after approval by the Secretary of State, was operational by 1 November 2013. This rapid pace of change was greatly helped by two factors: first, Trafford's own recognition that it was no longer viable as a standalone organisation; and second, a coherent set of commissioning strategies between the local



commissioners in Trafford and those covering a Greater Manchester-wide footprint. At every stage there was a strong degree of alignment between the different stakeholders, including (importantly) the regulators.

The new service model was developed on a multi-professional, multi-agency basis. The primary consideration was ensuring that the services provided in Trafford would be clinically safe, but they also had to be financially sustainable for providers and commissioners alike. Alongside these objectives, there was a shared desire to maximise the range and volume of services that Trafford people could access at their local hospital, and also to give Trafford a new role in the Greater Manchester health economy.

The Trafford urgent care services clearly needed to be redesigned. Trafford patients were already being taken elsewhere for major trauma, acute myocardial infarction and stroke care, and the remaining activity was not sufficient to support a full A&E department, so the service was remodelled as an Urgent Care Centre. A triage arrangement was agreed with the Ambulance Service such that the most acutely ill patients are taken to other hospitals, and the service doesn't operate between midnight and 8am. However, it is still led by a team of A&E consultants, and has a full complement of experienced medical and nursing staff, so if and when acutely ill patients do attend, they can be safely cared for and stabilised before being transferred on. This means that about 75 per cent of the previous A&E attenders are still being cared for very effectively at Trafford. The Urgent Care Centre is supported by a 24/7 consultant-led Acute Medical Unit, so the vast majority of GP admissions can still be accepted.

Similarly, Trafford General was previously undertaking a very small volume of inpatient surgery across a number of surgical specialties, including small numbers of acute cases, and this was not sustainable. The new model of service has seen the transfer of elective orthopaedic work from Manchester Royal Infirmary to Trafford, and the establishment of the Manchester Elective Orthopaedic Centre, which now does more or less all the elective orthopaedic activity for the whole trust. At the same time, other surgical specialties have been rationalised, with day case work being maximised on the Trafford General site.

The Trafford site still plays an important role in providing general medical and rehabilitative inpatient care, particularly to frail elderly patients. It also offers



a comprehensive range of diagnostic services, and an expanded portfolio of outpatient clinics is being provided so that patients do not have to travel into central Manchester so often for specialist services.

The modelling was developed by an extended group of local stakeholder organisations, and the commissioners provided a clear lead in seeing through the consultation and decision-making processes. Making a broad range of safe and sustainable services available locally has been possible because Trafford, while being a separate hospital division, was also part of a bigger, integrated, general and specialist hospital services group. This allowed us to establish patient pathways that can include the planned transfer of patients between sites, depending on their needs, and as they move between acute and rehab phases of an episode. In many cases we are, in effect, delivering single services over more than one site. This approach is now being looked at in the context of broader strategic planning for the future of hospital services in Greater Manchester.

The hospital at Trafford is now busier and more viable than it has ever been. We have been able to address and mitigate all the risks around small-scale services (eg, intensive care, acute surgery). We have also been able to significantly improve the ward staffing levels and address longstanding recruitment and retention issues, as staff now rotate across the whole trust. We have also seen a significant improvement in incident reporting. The hospital standardised mortality ratio is down from 121 pre-acquisition to below 100. Financially, we've been able to eliminate the entire deficit over an 18-month period. This was delivered through improvements in productivity across a wide range of functions, including back office, estates and clinical support services, and changes to the clinical model; and again, we worked really closely with commissioners on all of this.

The sort of model we've developed with Trafford is clearly helped by geographical proximity. But I wouldn't discount the same sort of model working with a more geographically distant organisation. One of the disciplines it brought to us was to codify and catalogue all our existing clinical pathways and protocols more effectively. This meant that when we were effecting the acquisition, there was a very clear set of protocols and pathways in place that set out how we conduct our clinical business in our foundation trust. Part of the change programme was making sure that these protocols and processes would be followed at Trafford in the same way as they would at Manchester Royal Infirmary or any of our other hospitals. As long as



you can ensure such alignment and put in place a really clear management plan, I think this could potentially be delivered on a larger geographical basis.

Again, I wouldn't present this type of acquisition as a solution in every local setting; I just think it's one model that has worked well in Trafford. Part of our job collectively is to develop and sustain public confidence in the NHS. If one part of the NHS is not operating well, I believe it undermines the confidence of all our patients – they don't look at all the organisational boundaries, they just see the overall picture. There's a leadership challenge for us all to develop resilient local arrangements for the NHS that command the support of the communities we serve. There is a critical message we all need to play our part in communicating: that the agenda is not one of closing hospitals, but rather making them more relevant to their local circumstances. You can really create a sense of excitement and genuine positivity about that, as long as you get the presentation and language right at the outset. I think that is more important than whether the geographical distance between two hospitals or a group of hospitals is 5 miles or 20 miles – it's just really thinking through what role the local community and commissioners want the hospital to play in their health and social care system.

I believe passionately that we need to define an entirely different and more innovative local hospital sector to take us forward from the DGH model that served us so well in the past. I suspect that's probably why it's working in Trafford – it's now a busier hospital, clinical outcomes are better, the patient and staff experience and engagement are up, and it really does feel like a vibrant and sustainable local hospital.



6 Dr Steve Dunn

Director of Delivery and Development, NHS Trust Development Authority (TDA) (South region)

For more than 10 years, Steve Dunn has been leading the creation of a more commercial and competitive NHS. As a senior civil servant in the Department of Health, he was a principal architect of the flagship foundation trust policy and Director of Policy on the Our health, our care, our say White Paper. He is also the architect of the first competitive NHS acquisition at Bedfordshire and Luton, and of the innovative operating franchise at Hinchingsbrooke. In 2012, Steve introduced the Friends and Family Test into hospitals across the Midlands and East Anglia. The test was endorsed by David Cameron for roll-out across the rest of the NHS in 2013.

The NHS TDA exists to provide leadership, support, oversight and governance for all NHS trusts on their journey to providing high-quality services today that are also secure for tomorrow. This responsibility includes oversight of the performance management of 99 NHS trusts, providing around £30 billion of NHS-funded care each year; ensuring that they provide high-quality, sustainable services; and providing guidance and support on their journey to achieving foundation trust status.

How do we spread best practice around the NHS quicker than we have done in the past? That's the big question behind the idea of getting the best NHS organisations and chief executives to establish national groups of hospitals or services.

We need to tailor the solutions to the problems that we are trying to solve and the improvements in patient care we are trying to make. We mustn't be ideological. Chains must be a means to the end of delivering even better care to patients and taxpayers. Sir David Dalton's review needs to recognise this.

Take Hinchingsbrooke Hospital, for example. It is a well-loved local hospital. But it is in debt. And local NHS management predicted it needed an £80 million subsidy over 10 years to keep it open.



Circle's plan is to empower clinicians to drive up quality and avoid the need for a hefty subsidy. It has brought clinicians in from across the Circle partnership to share best practice. And this has worked – performance has improved, quality has improved, and complaints have fallen; the patient experience has been transformed, the building and estate have been overhauled, and staff turnover and absences have been reduced.

But such procurement processes can cost time and money, and they are not always the answer. In 2012, George Eliot Hospital NHS Trust decided that its financial problems would get worse and it needed to find a partner to help address the challenges and secure a sustainable future. It decided to pursue the Hinchingsbrooke path.

But in the summer of 2013, George Eliot, along with others, was put into special measures following the review by Sir Bruce Keogh. In response, the TDA rapidly put in place a series of measures to support the trust to improve, including buddying the trust with University Hospitals Birmingham NHS Foundation Trust.

Buddying – which involves a range of formal and informal mentoring and exchange of best practice – appears to have worked. The trust has delivered a range of improvements to care quality and performance over the past year.

What's more, the trust is no longer considered a mortality outlier. Its A&E department was one of the best-performing in the country in December 2013 and January 2014. And the trust delivered notable improvements against a wide range of national standards, including waiting times, sepsis care, ward moves and the number of pressure sores reported.

So we had to make a decision. Did we abandon the procurement process or the buddying process? It was a tough call, but we formed a judgement that the relationship with University Hospitals Birmingham was the best way to achieve further improvements to services for patients, and that the procurement process should be brought to a close.

The problem wasn't that the private sector or other NHS organisations couldn't help. The issue was that buddying was working. And although there is a great deal of work still to do if the NHS wants to regain the trust of the public post-Francis, then we had to back buddying arrangements.



The public wants high-quality, safe services. And it wants challenged providers to learn from the best, like University Hospitals Birmingham.

Our overriding priority must always be the quality and safety of services available to local patients. Using buddying, mergers or acquisitions, or franchising must always be a means to this end.

Each and every trust faces unique challenges and this means that the solutions are also likely to be unique. The interventions and improvements at both Hinchingsbrooke and George Eliot are success stories. But they are very different models that must be applied critically.

There shouldn't be only one model for enabling the best-performing NHS organisations and most successful chief executives to establish national groups of hospitals or services as beacons of excellence. I hope Sir David Dalton acknowledges this in his final report.



7 Steve Melton

Chief Executive Officer, Circle

Steve became Chief Executive Officer of Circle in December 2011. He has more than 30 years' experience leading large-scale operations. Before Circle, he was the Supply Chain Director at Argos, where he led its business excellence programme. Previously, he was Supply Chain Director at Scottish Courage Limited, managing more than 3,000 staff and he was part of the team that turned Asda around in the 1990s. He began his career on Unilever's Management Trainee Programme, and holds an MA (first class) in Chemical Engineering from the University of Cambridge.

Circle is the largest partnership of doctors and nurses in Europe. It was founded with a social mission to make health care better for patients, bringing together leading clinical expertise, business innovation and world-class patient-centred services to transform hospitals. Circle is co-owned and run by clinicians, meaning that all partners are empowered to put patients first in everything they do. It is a partnership of more than 2,000 consultants; runs two independent hospitals in Bath and Reading and the largest independent sector treatment centre in Nottingham, and, in February 2012, became the first (and to date the only) independent sector organisation to run the management for a full NHS hospital, Hinchingbrooke Health Care NHS Trust, near Cambridge.

An NHS hospital in Huntingdon is changing everything we thought we knew about small hospitals.

It is proof that the small district general hospital (DGH) is not dead and that 'chain hospitals' – linked together through networks of clinicians and services – can improve care, reduce costs and become financially sustainable for the future.

Hinchingbrooke Hospital treats 40,000 emergency patients a year – less than any other accident and emergency (A&E) department in the country. It has the second smallest income of any trust in England, and it delivers fewer than 2,500 babies a year. Yet despite this, on almost every conceivable measure, it is now one of the top-performing trusts in the United Kingdom.



Two years ago, this wasn't the case. A&E performance was poor, serious concerns had been raised about colorectal surgery and serious incidents, and enforcement actions from the Care Quality Commission (CQC) had been ignored. The hospital was running a £10 million annual deficit and was experiencing such serious problems that it faced imminent closure.

Under the previous government, Labour's Health Secretary, Andy Burnham, took the bold decision to begin a franchise arrangement to save the hospital. Circle won the contract and started work in 2012.

In the two years since, Hinchingsbrooke has undergone one of the most profound employee-led transformations of any hospital in the country.

A&E is now ranked among the top 10 in England according to patients and waiting times; colorectal services have been fully restored; and we are fully CQC-compliant for the first time since inspections began. At the same time, the £10 million annual deficit has been reduced by 90 per cent and we soon expect to be in financial balance for the first time in years.

Many people never thought this was possible.

For years we've heard people say that a small hospital, surrounded by three large specialist trusts, wasn't viable and couldn't survive. These same people frequently argue that we must continue to centralise health services in England, creating ever-larger specialist hospitals and 'reconfiguring' our vital small hospitals almost out of existence.

These people are wrong – and I believe our case study proves it.

The transformation at Hinchingsbrooke Hospital over the past two years has been the result of three key factors: genuine clinical leadership and empowerment; integrating best practice solutions from all sectors and industries; and networking hospitals together to create critical economies of scale for learning and efficiency.

The first two of these are well researched. Governments of all colours over the past two decades have embraced involving doctors and nurses in frontline



decision-making and bringing together the best of the independent and voluntary sectors to build innovation and spread best practice.

Now, finally, the last of these three crucial ingredients is beginning to gain traction as well – and Hinchingsbrooke’s track record shows that it works in three key ways.

First, we were able to network Hinchingsbrooke with more than 2,000 consultant partners, many of whom are national leaders in their specialisms, in four hub hospitals across the country. When Hinchingsbrooke suspended colorectal surgery over longstanding concerns from the Royal College of Surgeons, we were able to bring in national experts from our Nottingham hospital to lead the transformation that would see full services restored in less than a year, two new permanent consultants appointed and a fully compliant audit received from our inspectors.

Second, we were able to link Hinchingsbrooke into partnership-wide forums to share best practice and speed up innovation. We hold partnership sessions with the boards of all sites at least twice a year; we have a nursing forum that includes elected representatives from every hospital, which meets once a quarter; and we have integrated governance teams to make sure everyone is held to account.

Third, we were able to pool resources between Hinchingsbrooke and our other sites, creating far greater economies of scale and building efficiencies across procurement, communications, HR and administration.

We have seen first-hand the huge efficiency gains this has allowed us to make, improving patient quality while lowering costs, and securing our hospitals for the future.

Sir David Dalton’s timely Department of Health review into ‘chain hospitals’ will help the NHS meet the unprecedented financial challenges ahead. What’s more, it will be critical in keeping open small district general hospitals that are a lifeline for millions of patients, delivering better local services to local populations, and joining up care across the country.

The government has seen the value of hospital chains – now we need to see them delivered.



8 Lucy Heller

Managing Director, ARK Schools

Lucy Heller is Chief Executive of ARK, an international children's charity focusing on education, health and welfare. Lucy is also Managing Director of ARK Schools, which she has led since its inception in 2004. ARK Schools is one of the UK's top-performing academy groups and currently runs 27 academies teaching more than 9,000 pupils in some of the most under-served areas of London, Birmingham and Portsmouth. ARK Schools aims to ensure that all pupils, regardless of their background or prior attainment, perform well enough in school to succeed at university or in their chosen career.

Lucy joined ARK Schools from TSL Education, a subsidiary of News International, where she was Joint Managing Director. Her previous roles include General Manager of The Observer, Executive Chairman at Verso, and Managing Director, Capital Markets, at Manufacturers Hanover, a US commercial bank. She has worked for many years with a number of charitable and voluntary organisations, including the Marshall Commission, Community Links and the Bush Theatre.

ARK Schools is part of the international children's charity ARK, which runs a range of health, welfare and education projects in the United Kingdom, Southern Africa, India and Eastern Europe. ARK has established two external education leadership programmes, Teaching Leaders and Future Leaders, which train middle and senior leaders for inner-city secondary schools.

ARK is one of the most successful chains according to the Department for Education, operating 27 primary and secondary schools in different areas, including London and Birmingham (see www.arkschools.org/about-us).

I'm no expert in the workings of the NHS. But the things we've learned in running our schools might offer the health sector some useful lessons.

Of course, some things might not be comparable. As an example: measuring our success is relatively straightforward, since we can look at educational outcomes for



our students. I'm sure some good measures exist for the NHS, but they may be more complicated – there may not be so regular a pattern as, say, looking at the number of pupils in certain year groups who are achieving certain results.

But I'd say that the complexity of running an academy chain is broadly comparable with running a health network; as individual buildings, schools must be among the most intensively used during working hours. Also, the complexity involved in driving the right outcomes may not be dissimilar.

For us, some of the economies of scale can sound a little unromantic and unappealing. But in practice, there are things that could work well in the health sector. For instance, chains can do the key work of developing people, creating career opportunities across a network in a consistent way. They can commit the level of investment needed to have really good training and recruitment. Also, there's that sense of creating a great collegiate spirit across a well-functioning network, where everyone is working together towards the same mission.

One of the trickiest challenges for a network or chain is getting the right balance of devolved autonomy and accountability. Our headteachers are strong individuals whose schools reflect their pupils, parents and local community – but they're also part of the wider ARK network, and we all want to keep standards consistent. I wouldn't say we're at the final conclusion; it's a continuing work in progress to get this right. Generally speaking, though, we work on the concept of earned autonomy. This leaves our outstanding headteachers free to create their own schools, within an agreed set of parameters about the way we work and the kind of reports we use. If they find a better way of working, we'll say: great, let's do this across our whole network. We continually recast the balance to make sure things are going right, and our reporting systems and monitoring visits allow us to step in if anything needs to change.

I think that, in health chains, services could still be tailored to local needs, and could still be locally accountable within a wider governance model. This is certainly how we work: although they're part of a network, our schools all have locally based governance. The ARK Schools board is the legal governing body, but it delegates day-to-day responsibility to individual school governing bodies, made up of local people who reflect the nature of their communities.



For any network, it's important to capture and share best practice – a lesson we've had to learn painfully over time. We started from scratch, as a children's charity that wasn't involved in running schools. Our first Director of Education, an inspirational American, talked of 'building the plane as we fly it', which sounded good but had a few stresses. We discovered, as we went along, what best practice was and how to transmit it, and we're still learning. However, there's probably a lot of information available already about how to share best practice in the NHS.

Like other academy chains, we've achieved some good results – and evidence shows that, on average, academy chains perform better overall than individual academies. Saying that, this average disguises a normal bell-shaped performance curve. We must remember that the chain format isn't a 'silver bullet'.



9 Dr Anthony Marsh

Chief Executive, West Midlands Ambulance Service NHS Foundation Trust and East of England Ambulance Service NHS Trust

Anthony Marsh started his ambulance service career in Essex in 1987. Anthony held a number of senior posts with the ambulance service in Hampshire, Lancashire and Greater Manchester before returning to Essex as Chief Executive in 2003, relocating to the West Midlands Ambulance Service in 2006 as Chief Executive Officer.

Anthony holds a Master of Science degree in Strategic Leadership as well as a Master of Business Administration (MBA).

In 2011, Anthony was decorated with the Order of St John. In addition to his responsibilities as Chief Executive, he was appointed Chair of the Association of Ambulance Chief Executives. Anthony has been awarded a Doctorate by the University of Wolverhampton. He was awarded the Queen's Ambulance Service Medal in the 2014 New Year's Honours.

The leadership qualities required to lead more than one NHS provider trust are all about creating service improvements for staff to enable them to provide the highest standard of care for patients, and creating the environment in which staff can produce the best patient services they can. An organisation founded on this principle will meet the needs of patients through motivated and supported staff.

To achieve that aim, it first matters what you choose to pay attention to. Ambulance trusts are big organisations in size and scale, and are geographically disparate in a way that hospitals are not: most of our staff don't work where they are 'based'.

Second, you must be very clear about your priorities. That means you need to clearly state your objectives, and manage your strategic risks by having your best people in the most challenging leadership roles.

The ambulance service has seen significant rationalisation since the 2006 reforms, which resulted in a reduction from 31 ambulance services to 11. That change



produced excellent results in improving efficiency and patient care. There have also been ambulance mergers in Wales and Northern Ireland.

It's too early in the current review of organisational structures to make predictions about the direction of travel on shared leadership or consolidating management structures. If further improvements are to be achieved by closer working, then we should explore how to deliver that; locally, we've had no decisions or indeed discussions about that.

In terms of the governance implications of having a shared leadership role, both West Midlands and East of England have their own chair and boards. Clearly, different governance models might be possible. The point is that the key to being successful remains getting the best people in the most challenging and complex roles in any NHS organisation, whatever its governance arrangements.

The other key to success is to create services that are tailored to local communities: the needs for ambulance services in inner-city Birmingham and rural Norfolk communities are very different.

Whatever governance arrangements and strategic leadership you design, you always need local leadership capable of delivering bespoke services to meet the local population's needs.

I also think the public sector has developed a recognition of the need to find really good strategic leaders, who are ready and capable to take on challenging and demanding organisations. It seems to be increasingly difficult to find people with the ability to undertake these roles.

So we need to look at innovative ways of getting leaders into these roles, and at economies of scale to bring efficient and effective arrangements to maximise public spending on the front line. If we can streamline decision-making, improve the supply chain and procurement processes to reduce cost and improve quality, and provide locally tailored services, that surely must be the best model to support local staff to deliver high-quality care for patients.

The management chains concept seems an exciting and innovative opportunity for the NHS and other public services to take forward. It strikes a balance between



opting for mergers, which make some people anxious, and recognising the real shortage of talent and expert leadership to take increasingly complex organisations forward in a foreseeably tough financial environment. The chains model could be an excellent opportunity to take forward new ways of working and achieve substantial benefits.

The buddying concept seen with the Keogh 14 [the 14 hospital trusts investigated as part of The Keogh Mortality Review] is good, but depends on what problem we're trying to solve. For some organisations, support and buddying is probably what's required. Others need strong leadership to take forward necessary improvements, and so need a strong leader and chief executive and a well-led board for sustainable change. It's all about meeting local needs.

Sir David Dalton's review could first look at leadership qualities and how they're aligned to the most challenged organisations in each sector. If you just look to the top 12 most challenged NHS provider organisations, some might not be from relevant sectors of mental health, community or ambulance, so maybe the focus should be on the bottom quartile in each sector.

Next, it's helpful to look at the available individual leadership talents, and how to align them with need in each sector. How can the system provide leaders with support and incentives to take on challenges? Troubled organisations are rarely quick turnarounds: the work is often long and difficult, and can be quite isolated. How can the system provide meaningful and robust support arrangements tailored to local circumstances and individuals?

Finally, have we got the right set of national policy drivers in place? If the answer to our question is management chains, then the fit with current policies to maximise competition and choice is not obvious. We've had foundation trusts for 10 years, and now just over half of NHS providers are foundation trusts. Do we have to wait another 10 years?

I think we need to do something different. This management chains idea could really work and is absolutely welcome, but we need the national policy infrastructure in place to support it, or we won't go far enough, although it's a good idea. That would be a great loss and a big shame.



10 Andy Brogan

Executive Director of Clinical Governance and Quality (Executive Nurse), South Essex Partnership University NHS Foundation Trust

South Essex Partnership University NHS Foundation Trust (SEPT) provides integrated care including mental health, learning disability, social care and community health services from more than 200 locations across Bedfordshire, Essex, Luton and Suffolk, employing around 7,000 people and serving a population of 2.5 million.

Andy is Executive Director of Clinical Governance and Quality, and the Executive Nurse at SEPT. He joined Bedfordshire and Luton Mental Health and Social Care Partnership NHS Trust in September 2009 and now works for SEPT across Bedfordshire, Essex, Luton and Suffolk.

Andy has a wealth of experience within the NHS and the private sector. He has held a variety of nursing director and governance posts, as well as spending time at the Care Services Improvement Partnership and the Department of Health.

South Essex Partnership University NHS Foundation Trust (SEPT) has a history of pursuing innovative organisational models. In 2010, SEPT acquired Bedfordshire and Luton Mental Health and Social Care Partnership NHS Trust, which was struggling with quality issues at the time. The acquisition involved a formal bidding process in which SEPT was successful, despite not being geographically adjacent to either Bedford or Luton. We have gained significant and valuable experience of managing a 'chain' of sites across geographical distances. SEPT has since bid for and acquired contracts to provide community services in Bedfordshire and Essex, enabling integration between mental health and community physical health services across the localities we serve.

There have been challenges in making the model work, especially when a wider geographical area is involved. We spent at least four years aligning culture across the trust and investing in process redesign and standardisation. Travel times from our Essex headquarters to Bedford or Luton are over two hours, and face-to-face interaction becomes much more difficult when you're working across a



larger geographical area. Therefore, we invested in technology, especially video conferencing, to reduce travel times and keep people connected.

We are proud of our achievements and have benefited from standardising clinical and quality standards across our different sites. Policy alignment is also something that needs careful consideration and, despite the acquisition, we chose to invest time in maintaining a localised model. This is underpinned by patient and service-user involvement, high-calibre local management groups, and a locality sub-committee structure that takes greater responsibility for scrutinising performance and providing assurances to the board, which has become more strategic in its leadership and oversight. SEPT retained a central corporate function rather than moving to an integrated business unit model, and this has worked successfully, especially as contracts now require a lower margin.

It is worth noting that mental health trusts will have considerable experience to bring to the debate on organisational form, as our boards, clinicians and frontline staff are familiar with working across larger geographical areas and assuring quality across multiple hospital and community sites. The trust also invested time in bringing managers and staff from different localities together, in addition to the locality work.

While our acquisitions have been successful, there may well be equal benefits to be gained by trusts exploring strategic alliances and collaborations within their local health economy. Trusts considering acquisitions and mergers will need to undertake careful due diligence and consider potential exit issues that may arise as the NHS moves towards more market testing.

SEPT is piloting a lead provider contract for the frail elderly, working closely with local authority partners and colleagues in community and acute care. This is one of the future models that will be around in the NHS going forward, and we have taken the time to work through our respective accountabilities carefully with our partners. This is proving a good model for more integrated care, which we are keen to roll out further.

SEPT is a subcontractor for specialist children's services in Suffolk within an independent provider's contract. The cultural differences have been apparent, and both SEPT and local commissioners have had to handle public anxiety about the



use of an independent provider for NHS care. One area to note was the independent sector's approach to logistics and back-office support and focus on the terms of the contract. There has been considerable learning for both parties – it certainly hasn't been a case of 'public good, private bad'.

We are seeking a number of collaborative alliances with neighbouring trusts in all sectors – and, of course, with our local authority partners in which the Better Care Fund is acting as a galvanising force. It may be that the nature of some mental health and community-based services lend themselves to these collaborations in a positive way because we have shared experiences of delivering services within a community setting.

To conclude, we have learned that as a significant provider in our area, we have to be pragmatic and flexible and exploit strategic opportunities to share premises and back-office functions. We need to meet the needs of diverse populations and respond to patients' changing expectations, and also thrive in the current environment in which system leadership can seem lacking where we serve eight disparate clinical commissioning groups. The Dalton review is a great opportunity to explore the full range of organisational models open to foundation trusts to meet these challenges.



11 David Hamlett

Senior health care partner with Wragge Lawrence Graham and non-executive director of University Hospitals Birmingham NHS Foundation Trust

David specialises in corporate and commercial transactions in the health care sector and regularly advises hospital boards on governance-related matters. He is recognised for devising solutions in even the most politically charged situations. David's clients include a wide range of UK and international health organisations.

It is not tenable to have the current number of foundation trusts and acute trusts operating independently in the NHS. Currently, there are not enough good leaders, there is wasteful duplication, and no uniform best practice. We need better organisational arrangements to drive improvement in the NHS.

Consolidating hospitals into geographically spread 'chains' would allow the best foundation trusts ('lead foundation trust') to head a chain of trusts dedicated to raising quality and increasing efficiency, eg, reducing the number of duplicated senior administrators and having a consistent best practice approach within the chain.

There are a number of possible models for these new organisational arrangements.

- **Holding company** A full merger of link trusts and lead foundation trust into a single foundation trust – thus a single board of directors, council of governors and membership. This would be representationally challenging as chains are likely to be spread geographically rather than concentrated to preserve choice and avoid competition issues. The ideal might be, say, 10 chains represented within a 20-mile radius of central London.

Mergers will have to comply with the current merger requirements and there would need to be new legislation to deal with members and governors from the different locations.



At present, it is not possible for a foundation trust to have viable subsidiary foundation trusts (with their own boards, etc). This would be a better solution and allow more local representation, but for this to happen a change in the law would be needed.

- **Statutory franchise** The example of Hinchingsbrooke Health Care NHS Trust (see contribution from Steve Melton, p 38) utilises existing legislation for failing acute trusts. The trust is currently run by Circle as a statutory franchise, giving Circle the power to make decisions on behalf of the trust, but all the staff remain within the trust and the NHS. Under the franchise agreement, if the hospital is not operated in compliance with financial and clinical parameters, no management fee is payable and Circle partially underwrites trust deficits. There is financial incentive and financial accountability. The parties remain separate, so there is no balance sheet consolidation between Hinchingsbrooke and Circle.

However, the legislation enabling the statutory franchise agreement currently only operates for failing acute trusts. If the statutory franchise model is to be more widely implemented new legislation would be needed to extend and improve the franchise concept to enable chains to operate without the balance sheet merger.

- **Affiliated model** An affiliated model is similar to systems currently used in the United States. This would be a contract between the lead foundation trust and the link trusts. The lead foundation trust would provide leadership, common methodologies, expertise, IT, management, training, and enforceable brand standards. The lead foundation trust could appoint one of its directors to be on the board of a link trust, which would remain independent but be contractually bound to follow the requirements of the affiliated model contract.

For this option, no new legislation would be needed but there would be procurement/competition issues (see below).

- **Buddying** This option involves the provision of advice/expertise, but with autonomy within the link trust to decide whether to take that advice. This would effectively be management consultancy. This approach is currently used in



education but should ideally be coupled with appropriate board appointments. It would rely, to a large extent, on strong personalities/relationships.

In addition to opportunities the above mentioned models would pose a number of challenges.

- **Regulation** The holding company and statutory franchise models would need regulatory adjustment and regulators would need to consider whether to regulate the links, or the chain as a whole with accountability resting with the lead foundation trust. The affiliated and buddying models are contractual; the trusts remain in place and regulated individually.
- **Patient accountability** Consideration would need to be given as to how patient accountability, Healthwatch, etc, would be incorporated into a new chain structure.
- **Vires** There are vires considerations for both foundation trusts and acute trusts, depending on the model.
- **Procurement** Procurement is not required to find a new takeover partner, but will apply if procuring services (as in the affiliated and buddying models). It may also apply in relation to the franchise. There are exceptions to procurement, eg, an internal NHS reorganisation. However, there is likely to be a call from the private sector to be allowed to participate.
- **Competition** Competition law applies to mergers and the creation of these chains could count as a merger. For some options, there would also be contractual requirements (affiliated model) that may be potentially anti-competitive (eg, sharing cost information).
- **Commercial considerations** The impact of creating new organisational models on other NHS organisations and any adverse consequences requires thought across the wider system and raises a number of questions, including: What would the risks/rewards be for the lead foundation trust? Would there be a fee to be paid? Would the model be conditional on improved performance?



- **Patient choice** Patient choice must not be weakened by the introduction of new models, in particular if people are directed to one link in the chain rather than another non-chain trust.

In conclusion, I believe 'less is more'. The number of hospital organisations with a wide gap between best and worst in class must end. Chains are clearly the way forward.



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The King's Fund is an independent charity working to improve health and health care in England. We help to shape policy and practice through research and analysis; develop individuals, teams and organisations; promote understanding of the health and social care system; and bring people together to learn, share knowledge and debate. Our vision is that the best possible care is available to all.

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The Foundation Trust Network (FTN) is the membership organisation and trade association for the NHS acute hospitals and community, mental health and ambulance services that treat patients and service users in the NHS. The FTN helps those NHS trusts deliver high quality, patient focussed, care by enabling them to learn from each other, acting as their public voice and helping shape the system in which they operate. The FTN has over 225 members - more than 90% of all NHS foundation trusts and aspirant trusts - who collectively account for £65 billion of annual expenditure and employ more than 630,000 staff.

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With an increasing number of health care providers in deficit and others placed in special measures because of concerns about the quality of their care, how can the NHS tap into the experience and expertise of successful organisations to help those that are struggling?

As Sir David Dalton prepares his review, *Future organisational models for the NHS* explores the full range of organisational models that are already being used across the provider landscape, including buddying, learning and clinical networks, partnerships and joint ventures, management and operational franchises, hospital mergers, and hospital chains. It provides a review of the evidence on different models and presents perspectives and insights from some of those at the forefront of innovative organisational arrangements, in health and in other sectors, in England and elsewhere.

The common themes include:

- strengthening leadership and promoting greater continuity of leadership
- addressing the tension between central versus local control, and standardisation versus innovation
- giving providers greater freedom to choose the organisational structure that best meets the needs of their local population, underpinned by robust governance
- giving sufficient time for organisations to turn things around, especially those with a long history of performance challenges.

It is likely that greater collaboration, co-operation and, where necessary, consolidation between providers will often be part of the solution for raising standards and turning around performance. The individual perspectives in this publication show the challenges and opportunities offered by different organisational models.

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