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NHS CONFEDERATION

Healthcare groups: an alternative to merger-mania?

Key points

- Acute providers have in recent years pursued targeted alliances – 'groups' – to get the benefits of collaboration without the loss of autonomy required by a merger.
- Some of the pitfalls of whole-trust mergers might be avoided or minimised with more targeted alliances and groups.
- It is important that models are locally adapted, but there is little facility for organisations involved to share learning; the Hospitals Forum will develop a community of interest among interested leaders.

There is a growing consensus that NHS trusts in general, and the acute sector in particular, are about to enter a new phase of organisational consolidation. A combination of system pressures may mean a wave of mergers, as trusts look to increased scale as a means of weathering staffing pressures, declining tariff payments, long-term shifts in demand and, for some, the foundation trust pipeline.

Yet the track record for mergers and the "bigger is better" view is not good. Evidence suggests that objectives are rarely achieved or, if they are, are outweighed by the downsides of a larger, less agile entity.[1]

Seeking an alternative, a number of acute providers have in recent years pursued more targeted alliances – often termed 'groups' – to get the benefits of collaboration without the upheaval or loss of autonomy required by a merger.

With some of these arrangements now showing real promise, and leaders looking with interest to see what might be replicated, this *Briefing* summarises key learning from those who have already had involvement in developing healthcare groups and considers what might be done to take the concept further.

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What are healthcare groups?

The basic principle behind a healthcare group is that two or more organisations agree to formally work together on a specific area of shared interest. This could be neighbouring hospital trusts, or an alliance between providers of acute and local community or mental health services. Crucially, however, rather than coming together fully (in mergers), these collaborations are focused only on where they are most likely to have benefit. This could include:

- shared back office functions – for example, the North West Collaborative Commercial Agency (see page 6)
- unified training or research and development – for example, as exists across academic health science centres (AHSCs)
- joint investment in the expansion or improvement of new services – for example, 'virtual wards' across a community
- centralising a service to increase volumes and/or specialisation, or to improve its efficiency (see 'View from the service' on page 5).

Mergers vs. groups

The limitations of mergers, and whether more targeted alliances might overcome some of these, are discussed below.

(Missed) objectives of mergers

The most common reasons for NHS provider mergers are:

- to achieve economies of scale and scope
- to comply with national and professional standards on service delivery and training (for example, staffing ratios)
- to expand market power and position
- to share new capital investments costs across more than one organisation
- as a response to uncertain market conditions
- to remove 'excess' capacity
- to rescue a failing trust.[2]

However, evidence suggests that these benefits are unlikely to be achieved through merger. For example, analysis of the last peak in hospital mergers (between 1997 and 2006) found no significant improvement in productivity or quality, regardless of whether staff and bed reductions were achieved.[3] There is in fact evidence that efficiency actually begins to decline in organisations of more than 600 beds.[4]

A 2005 study of NHS trust mergers found that not only were aims missed, but merging organisations also encountered unintended negative effects. These included other service developments having to be put on hold, loss of managerial control and an adverse impact on staff morale and buy-in.[5]

A study by Finnamore Ltd has highlighted that economies of scale and scope are not the dominant driver of cost and financial performance differences between trusts.[6] Instead, the data implied that other factors had greater influence on performance, such as demographic differences, different levels of efficiency, organisational capability and culture, and the relative level of local competition. However, Finnamore's own experience of working with trusts is that economies of scale do exist and that benefits can be achieved by increasing scale, although these benefits appear to be masked in the published data by other factors.

These findings are not unique to healthcare:

> "The experience of company mergers suggests what to expect when health and social care organizations merge: that is, strategic objectives are rarely achieved; financial savings are rarely attained; productivity initially drops; staff morale deteriorates; and there is considerable anxiety and stress among the workforce"[7]

Would 'groups' perform better?

Although the idea of alliances or groups as an alternative to merger are not new,[8] there is less evidence on their merits. It is impossible to say with any confidence what advantages groups might have over whole-trust mergers, but it seems intuitive that some of the pitfalls highlighted above might be avoided or minimised.

For example, the merger of a single service or department may be less challenging than that of a whole organisation. If partners are clear as to the particular benefits they can achieve together, an alliance specifically in that area might be

more likely to stay focused on – and achieve – its objectives. A focused partnership might also be less likely to cause disruption and inertia in other parts of the organisation. It may be that knock-on effects are more contained.

While workforce fatigue is a significant risk to trusts that are no stranger to reorganisation, there is some evidence that collaborations focused on specific services for specific ends would have greater acceptability to staff than whole trust mergers.[9]

Possible forms of healthcare group

Finnamore has developed a 'step change model' to highlight the different forms and levels of integration that are possible (see Figure 1).[10] The model highlights:

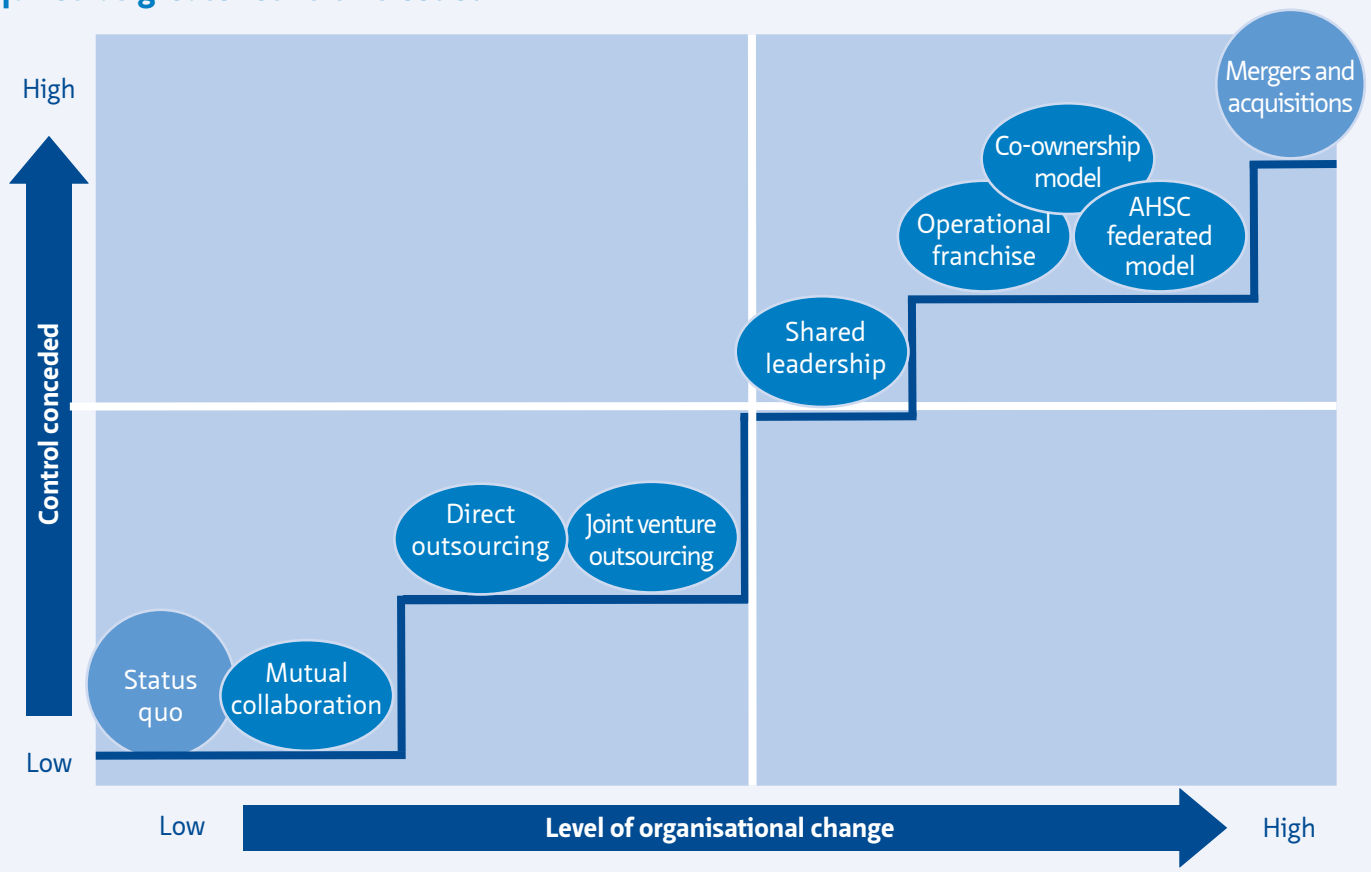
- there is, to some extent, a trade off between the degree of autonomy retained by partners and the benefits of collaboration they may hope to achieve
- different degrees of alignment are possible between informal joint working and full merger
- there is a tipping point in these degrees of cooperation, whereby change goes from being functional (affecting parts of a trust) to organisational (affecting the whole).

'Functional' collaboration

Functional forms of collaboration are principally based around shared or delegated service contracts. They have the advantage of requiring minimal organisational upheaval and focusing objectives (efficiency, sustainability or quality) around a specific set of services. There are three types of functional collaboration:

- Mutual collaboration – Resources for a particular function or service are pooled across two or more trusts. This can happen with minimal or no new legal structures and might be managed through a joint committee of the organisations involved. Clinical and financial accountability remains within the respective trusts.

Figure 1. Step change model showing the degree of organisational change required as greater control is ceded



Source: Finnamore Ltd

- **Direct outsourcing** – Partnering trusts sub-contract a particular service either to a third party (public or private sector) or to one of the providers within the group. This is usually managed via a service level agreement but accountability for service standards remains with the providers initially contracted by the commissioner.
- **Joint venture outsourcing** – Services are sub-contracted to a joint venture (a partnership between one or more NHS trusts and a private sector organisation, with the trust acting as commissioner). Accountability for delivery remains with the trust.

'Organisational' collaboration

Organisational collaboration moves beyond joint activities between two separate trusts and starts to formally entwine the leadership and management of each together – while keeping both as separate legal entities. There are different degrees of organisational collaboration:

- **Shared leadership** – To facilitate the bringing together of one or more services, partnering trusts can jointly appoint individuals to leadership positions in both. This may mean a director of a particular service sitting on either their boards, or even the appointment of a joint chief executive officer or entire management team. Clinical responsibility remains with the individual trusts, because the individuals in joint posts – although employed by both – are acting on behalf of each individually.
- **Operational franchise** – Responsibility for all (or almost all) of a trust is delegated to another organisation. Franchising differs from a merger or takeover because it is usually done through a fixed term-license, and the existing organisation can remain as a 'shell' with ownership of the property, assets, staff and ultimate accountability.
- **Federated model** – Partner organisations delegate responsibility for aspects of their management and/or leadership to a group organisation, which they co-own. The sovereignty (and responsibility for service delivery) is retained by each member, but some key decisions and functions are made the responsibility of an overarching group board, which each member is represented on to a greater or lesser extent.
- **Co-ownership** – This is essentially a collaboration between an organisation and its employees. Staff are given a significant but minority stake in the ownership of an operating company, which manages the provision of the services they deliver. Through this model, functions from different providers can be joined up if staff from the different providers are eligible for co-ownership.

There is a trade-off: as the degree of collaboration increases, the level of autonomy retained by partners decreases. Each of the forms above have strengths and weaknesses, but they are by no means mutually exclusive. It is clear that when choosing a form, trusts should be very clear about what they want to achieve from a partnership. The following factors are key when addressing this question:

- the geographical proximity of potential partners
- the effectiveness of their existing leadership
- the current service quality within them
- the extent of strategic alignment that currently exists between them

Key recommendation from Finnamore

When developing options for potential healthcare groups it is important to ensure the form of the group follows the functions required. Very often it is easy to get absorbed in governance issues without sufficient clarity on the business case and objectives of the group.

At the heart of a successful healthcare group is a core set of relationships between the parties – not just at the executive level, but throughout both organisations, especially between clinical staff. This provides sufficient trust to ensure any blockages to successful working can be navigated.

View from the service: "Let people be your focus"

"Our partnership with Salford Royal NHS Foundation Trust began as the scale of the NHS' £20 billion challenge dawned on us and we saw the pressures this was likely to create on the acute sector. We are both highly successful foundation trusts, but the economics meant that the old stance of 'competing for growth' no longer made sense. Our strategies had to adapt to the changed times.

"Our principal drivers were clinical and financial viability. However, we soon found that although the service models, business cases and governance were fairly straightforward, it was the people side of the partnership that needed the most investment. It's the clinical and managerial relationships that produce and maintain the drive to make joint working happen.

"Our first lesson was to start small, to test out how the partnership was going to function. The closer you get to patient-facing services, the more contentious things become, so we started with some easier wins: pathology and decontamination. The first of these we've centralised into Salford, saving 20 per cent (now growing to at least 25 per cent) off the costs to both organisations. For the second, we've chosen to take both services off site and put a new, combined decontamination facility in the middle.

"The success has been such that we're now ready to start looking at other services such as the smaller surgical specialties – urology, ophthalmology and ENT. We see the joint venture as an omnibus – we've two passengers on board so far, but hopefully more to come.

"Three key things have worked in our favour. Firstly, we are a partnership of equals – there has to be a perception of a 'community of equals', particularly for clinicians to accept the idea of cooperating with teams they may previously have had some rivalry with. A sense of equality can still be achieved if the organisations are different sizes, however, as the creation of my trust from Wigan (larger) and Wrightington (smaller, but more specialist) shows. Secondly, we only accept options that are win-wins for all involved; win-lose will just never get off the ground. Thirdly, we share costs and benefits absolutely down the middle, irrespective of where the combined service is located.

"My advice would be that partnerships like ours are the way forward for many hospitals. Don't get too concerned with the structural detail – which isn't that problematic – but whatever effort you think will be needed to get people behind the idea and working together, multiply it by ten. It's the 'soft' side of joint working that is always the hardest."

Andrew Foster, Chief Executive, Wrightington, Wigan and Leigh NHS Foundation Trust

- current board governance structures and their performance
- the financial performance of potential partners.

The experiences of early adopters

The federated model: UCL Partners

UCL Partners (UCLP) is a company limited by guarantee that comprises of a number of partners, which each retain sovereignty. The UCLP board consists of the chairs and chief executive officers of the NHS trusts, the UCL vice-provost (health), the UCL research dean and the managing director of UCLP. There is an independent chair.

UCLP's strategy harnesses the opportunities provided by national reports and strategic initiatives related directly to healthcare delivery to 'translate' research progress into healthcare benefit and develop a robust biomedical science infrastructure. UCLP aims to manage information and improve efficiency by integrating the research and development offices, strengthening the clinical research facilities, integrating clinical trial networks and creating a joint commercial office that integrates and builds on intellectual property and industry activities.

Shared services: North West Collaborative Commercial Agency

The North West Collaborative Commercial Agency (NWCCA)

was created in 2004 by NHS trusts in Greater Manchester, and later Cheshire, Merseyside, Cumbria and Lancashire. NWCCA is 'hosted' by the Salford Royal Hospitals NHS Foundation Trust. All NWCCA employees are employed by Salford Royal, which provides certain specialist support services, for example human resources and finance, to NWCCA.

The aim of the group is to obtain better quality and value for money from its increased purchasing power. NWCCA has identified trusts with similar buying needs and has set up collaborative purchasing projects. It offers core services, including commercial advisory, collaborative strategy sourcing, commercial contract management and collaborative catalogue management. NWCCA has delivered savings of more than £90 million for member trusts and achieved a rate of return of 7:1 – in excess of the original target.

Collaborating on patient-facing services: Derbyshire Nurse Bank

The Derbyshire Nurse Bank was set up to provide an effective, efficient, flexible nursing and healthcare assistant resource to wards, departments and clinical areas for participating trusts. Derbyshire Mental Health Services NHS Trust manages the allocation and administrative functions of the bank.

When clinical or ward areas are having difficulty covering their nurse/healthcare assistant requirements with contracted members of staff, they are able to call a central number to seek additional support. The Derbyshire Nurse Bank attempts to fill area requirements with suitably skilled bank nurses/ healthcare assistants. If the Derbyshire Nurse Bank is unable to fill the requirement itself, it will liaise with nationally approved agency suppliers to do so.

Emerging issues

There is growing interest among hospital leaders for formal alliances and joint ventures. Where this has developed into action, trusts appear to be experimenting service by service and, with a few notable exceptions, have started at the less committal 'functional' end of the step model.

Work to develop groups locally is patchy and experimental, which may very well be a good thing. Yet as interest grows in these models, it is worth considering some of the issues that might emerge with increased adoption.

'Coopertition' in the acute sector

Will an increase in collaboration between acute trusts decrease the contestability of the market for hospital services and, if so, is this a problem?

The increased level of competition encouraged by the Health and Social Care Act 2012 may lead to some consolidation between NHS providers. This is an effect that has been well documented by similar reforms in the United States market for acute services,[11] where there has been a long-running debate about whether alliances between providers are being used to protect market position or to improve care.[12]

As local and national leaders try to predict what balance a 'liberated' NHS will eventually strike between competition and cooperation, there should be scope for organisations to develop novel approaches that test the boundaries of the new system – as others have called for.[13] It is worth bearing in mind that new entrants may have as much to gain (or lose) from 'groups' as incumbent providers. From the examples already in existence, groups appear equally likely to provide opportunities for the independent sector as they do for the NHS.

The risk of failure

One of the risks of experimenting with groups is that some ventures may fail. Within trusts there will be different levels of expertise in devising and managing partnerships, and it may be that this is an area to prioritise in shared learning and support between hospital leaders.

Even strong partnerships sometimes fail. With shared services in particular there is a risk that if one partner fails or pulls out, the other is left having to support it alone. The more critical the service, the more important it is for partners to plan exit strategies. Risk (and reward) sharing will be an important area for leaders to look to early adopters for learning. For larger ventures it may be that a risk-pool or insurance scheme amongst the members is an attractive option.

Fit for what purpose?

With a number of uncertainties around healthcare groups, it is vital that acute providers

are allowed space and support to experiment with their use. There is currently no consensus or evidence to suggest what situations they are best suited to, but in the near future we will see a larger range of applications. Key questions include:

- Are groups feasible only for already stable and sustainable trusts or might they also be effective at rescuing troubled and even failing organisations?
- Can successful alliances be formed between organisations of considerably different size?
- Will groups have the effect of further supporting centralisation of services, or will they offer models that help sustain the operation of smaller sites?
- What level of resistance is there likely to be for trusts that enter into 'organisational' group forms? Will reduced local autonomy be opposed and, if so, by whom?
- Why is it that, amongst all the diversity of models developed or in development, we see none that meaningfully involve primary care? Would such alliances work?

Confederation viewpoint

A great benefit of the interest that healthcare leaders are showing in developing group-like arrangements is that models are locally driven and locally adapted. Important though this is, there seems to be little facility for organisations involved or interested in these approaches to share learning.

We would like to use the NHS Confederation's Hospitals Forum to develop an informal community of interest among local hospital leaders who are developing groups. If you are interested in participating, please email Viviana Olivetto, Policy Manager, at viviana.olivetto@nhsconfed.org so that we can inform you of this work as it begins.

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