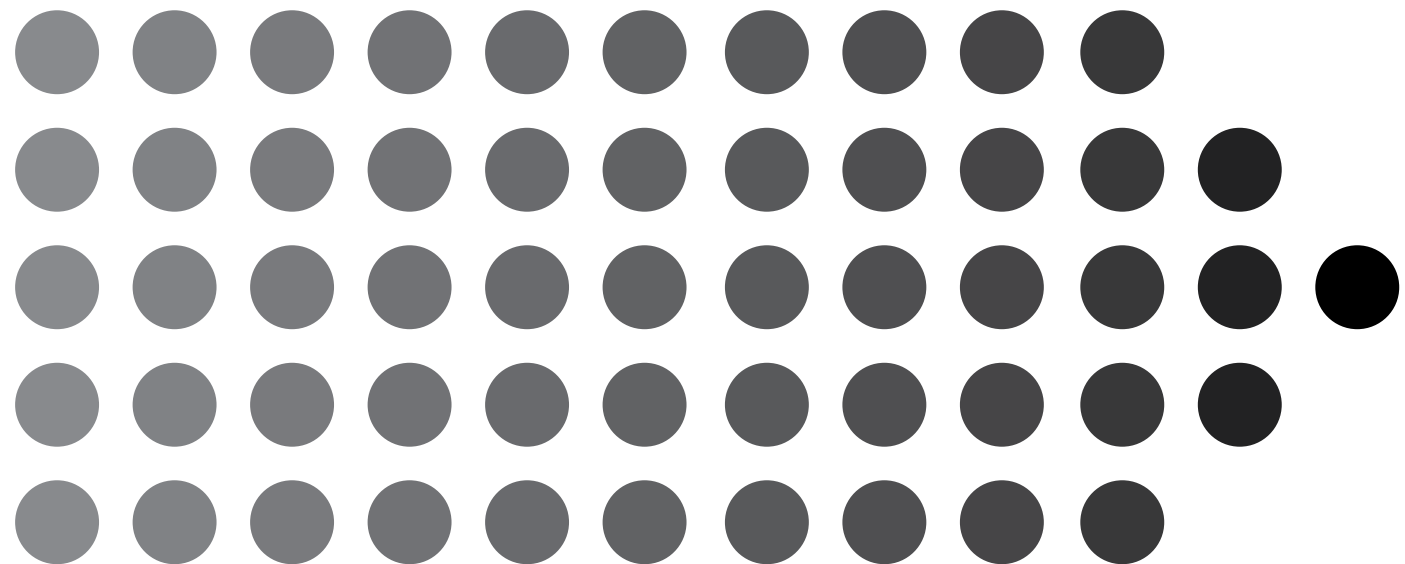


Form follows function

Governance challenges
for providers in light of
the Dalton review



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Introduction

This joint NHS Providers and NHS Confederation report explores the governance implications of the different organisational forms proposed in Sir David Dalton's review of organisational forms, published in December 2014. The review was a welcome step forward in providing a menu of 'delivery vehicles' that might be adopted by NHS organisations to practically implement the new models of care envisaged in the Five Year Forward View.

The central insight that inspired the establishment of foundation trusts was the need to make NHS organisations fully accountable for their own leadership and direction and more answerable and responsive to the communities they serve. Any organisational change must preserve these core principles of good governance.

Boards need to be clear sighted about the dilemmas and potential pitfalls of these new models from the outset. Only then can they design robust governance arrangements that help to realise the potential benefits these new organisational forms could deliver to patients and service users.

"The Five Year Forward View acknowledges the considerable achievements the NHS has delivered to date, and sets out a compelling case for change, based on promoting wellbeing and preventative measures, continually improving care quality and ensuring the system operates with maximum efficiency."

The context

The Five Year Forward View (5YFV) acknowledges the considerable achievements the NHS has delivered to date, and sets out a compelling case for change, based on promoting wellbeing and preventative measures, continually improving care quality and ensuring the system operates with maximum efficiency.

The 5YFV described a number of new models of care to deliver these aims, notably:

- multispecialty community providers – enabling groups of GPs to combine with nurses, other community health services, hospital specialists and mental health and social care to create integrated out-of-hospital care
- primary and acute care systems – combining for the first time general practice and hospital services
- smaller viable hospitals – new options, including those in the Dalton review, to help smaller hospitals remain viable, including forming partnerships with other hospitals further afield, and partnering with specialist hospitals to provide more local services
- enhanced health in care homes – new shared models of support, including medical reviews, medication reviews and rehab services.

Sir David Dalton's review explores seven organisational forms which providers may wish to adopt to help deliver these new, more integrated models of care. These forms are grouped under three themes:

- collaborative solutions – federations and joint ventures
- contractual solutions – service level chains and management contracts
- consolidated solutions – integrated care organisations, multi-site trusts and multi-service chain or foundation group.

Provider boards regularly review how their strategies and business plans support and enhance safe, high-quality and economically viable services for their populations – and both NHS providers and commissioners have been asked to give thought to the implications of the 5YFV and the Dalton review in their planning for next year.

‘Form follows function’

Any change in organisational structure arises from a strong business case to develop models of care for patient benefit (to improve outcomes, safety or experience), and/or to deliver a more efficient service, providing best value for the taxpayer and potentially releasing funds to reinvest in patient care.

While many of the organisational forms proposed in the Dalton review (such as joint ventures and federations for example) have been explored by a number of providers, the concept of a management chain or group structure remains unfamiliar in the English NHS. Crucially, there is limited guidance available about how NHS providers can put in place robust governance structures and local accountabilities to help ensure the benefits articulated in the business case are realised in practice.

This publication therefore:

- focuses on good governance from the outset as a critical factor in determining the success of any ‘delivery vehicle’
- reviews the importance of board assurance on the rationale for change, to ensure that form genuinely follows function
- explores the governance implications of adopting different organisational forms for the purposes of improving quality and/or efficiency, and provides some core questions for provider boards to use to inform their thinking
- signposts the information and support already available, including a series of practical checklists on each organisational form which were published by the Department of Health (DH) alongside the Dalton Review.

Given that Sir David Dalton’s work was primarily focused on exploring options for the organisational form of providers, this document’s primary audience is NHS provider boards. However, we recognise that new organisational forms will only succeed where commissioners are integral to discussions from the outset and in an environment where there is a shared focus across the local health economy on engendering collaborative leadership to drive change.

A core focus on governance

Recognising that 'one size doesn't fit all', the Dalton review proposes a menu of organisational forms, leaving it to provider boards to 'pursue the models that will deliver the greatest benefits to the populations they serve'.¹

As a joint review of existing practice by The King's Fund and NHS Providers makes clear, 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.² We do not yet have a body of evidence to suggest that one approach is demonstrably superior to the others.

What we do know is that there is a strong correlation between the effective operations of boards and organisational success. In each instance, clarity about the means by which the new organisation will be directed and controlled – the corporate governance arrangements – will be a critical factor in determining whether the new organisational forms deliver their intended benefits for patients and service users, and achieve clinical and financial sustainability over the long term.

This is not entirely new territory for NHS providers and there is much that has already been learnt. There are examples of many of the organisational forms underway across the sector – particularly federations, joint ventures, multi-site trusts and, increasingly, integrated care organisations, with trusts bringing together different combinations of acute, mental health and community services. However, in proposing a much wider adoption of these approaches and on a much larger scale, the Dalton organisational models pose a set of governance challenges that will need to be addressed by all provider boards, irrespective of their previous experience of organisational transformation.

The formation of a new legal entity is a well-established prompt for boards to consider whether there are appropriate governance arrangements in place. This report highlights that it is as important, and often more difficult, to get the governance right for the collaborative and contractual models envisaged in the Dalton report where the relationship between the parties is less clear cut.

The review rightly calls for a shift in the mindset of provider boards from service change as the prospect of their organisation 'winning or losing' to one where organisations work together to 'win' for their patients and wider community. However, notions of 'joint ownership and governance' need to be tempered by absolute clarity about where accountability lies. Greater collaboration and integration between organisations within local health economies hold great potential; however, it remains equally important that patients and communities know who they can hold to account for the services they receive, and what the process is for doing so. In addition, NHS provider boards will still operate for the foreseeable future within a regulatory framework that is institutionally rather than local health economy based.

This is why we believe a focus on governance is so important. Boards need to be clear sighted about the potential governance challenges of these new models from the outset. Only then can they design robust governance arrangements that help to realise the potential improvements these new organisational forms may bring.

Box 1: Monitor: Developing strategy – what every trust board member should know (October 2014)

Key questions: What should the board ask to assure itself at this stage?

1. Does your trust understand its external opportunities and challenges and its internal strengths and weaknesses?

Frame – Have we set aside enough dedicated time to ensuring we have an agreed view of what our strategy must achieve?

Diagnose – Do we have a shared understanding of which services are performing well and which particularly need improving? Do we truly understand the current perspective and anticipated future needs of patients?

Forecast – Rather than having just one view of the future, can we see how the trust would look in a variety of scenarios and can we as a board adapt to them as required?

2. Does your trust have robust solutions to address opportunities and challenges in light of its strengths and weaknesses?

Generate options – Have we sought inspiration from as wide a range as possible of sources in healthcare and other industries to identify our strategic options?

Prioritise – Is the board confident that the choices we have made will mean the trust is clinically, operationally and financially sustainable, while addressing the needs of patients?

3. Does your trust have the capability and a credible plan to deliver the strategy?

Deliver – How will we hold each other to account for delivery? Can leaders and teams at all levels explain the link between what they have to do and delivery of the strategy? What resources are required to support implementation of the strategy?

Evolve – How will we know whether the delivery of our strategy is successful and under what circumstances will we need to revisit it?

Form follows function: board assurance on the rationale for change

The Dalton review asked boards to actively consider whether to pursue new organisational forms as part of their 2015/16 strategic planning process. While there is a shared recognition that organisational form is never an end in itself, nor a guarantor of good performance, boards will need to guard against the risk that form takes centre stage rather than function, diverting attention from how sustainable improvements will be delivered for patients and service users.

It will be for trust boards to assure themselves that a new structure will genuinely deliver the outcomes they are seeking. We believe this assurance process must be based on going back to first principles: clarity on the strategic challenges and presenting problems that make change desirable and necessary, clarity on what the organisation is trying to achieve, and a thorough appraisal of the different options. Particularly important will be ensuring the drive to effect more rapid transformation does not obscure the risks to achieving current and proposed strategic objectives, and, in particular, that the capacity to deliver 'business as usual' is considered alongside the investment in leadership capacity and upfront resource required to implement any change itself.

To support NHS providers in their strategic planning exercises, Monitor has published a toolkit to enable boards to assess whether each stage of the strategic development process has been carried out effectively. It sets out three fundamental review questions and seven planning stages to help board members gain assurance on their organisations' strategic choices (see box 1 on page 5). As the toolkit makes clear, it is vital that plans align with those developed by commissioners and that they are based on common assumptions and a shared vision for service improvement and transformation.

The views of councils of governors will also need to be central to these discussions. The rationale for new organisational forms is that they will offer an opportunity to configure services in a way that leads to qualitative improvement. It is likely that this will involve quite radical change such that it will constitute a significant transaction under the Health and Social Care Act 2012, even if it falls short of a merger or acquisition. Foundation trusts will wish to take account of the views of their councils, even if they have not chosen to define significant transactions in their constitutions and of course some transactions will require the approval of councils of governors to proceed. Early engagement is therefore almost certainly the best way forward.

“The assurance process must be based on going back to first principles: clarity on the strategic challenges and presenting problems that make change desirable and necessary, clarity on what the organisation is trying to achieve, and a thorough appraisal of the different options.”

Governance challenges raised by the Dalton models

There are a number of governance challenges that apply to all of the models identified by the Dalton review, and indeed to any proposal for significant organisational change. The section below explores these issues before considering the governance implications of each of the organisational forms in turn.

The challenges identified are not intended to be a comprehensive checklist. We hope they will act as a high-level prompt to boards to promote prior discussion of key dilemmas as part of the decision-making process. NHS provider boards are encouraged to read this alongside the three evidence packs and practical checklists produced to accompany the main review report.³

As always, boards should make time to take stock before making a final commitment to organisational change to check that what they think they know is borne out by robust assurance.

Agreeing an achievable vision

Any proposed change needs to be based on a clear vision of how improvement will be achieved backed by sufficient evidence. Experience of transactions within the sector suggests that high performers sometimes find it difficult to replicate that performance having taken on a weaker organisation. This makes prioritising cultural change essential. In particular there needs to be a shared understanding between potential partners of why they are working together and what they are aiming to achieve. Time invested upfront in relationship building and cultural change is likely to pay dividends in terms of determining whether to proceed and on gaining early wins in a new organisation.

Effectively engaging stakeholders

Health services depend on collaborative rather than 'heroic' leadership, so commissioners must be integral to discussions from the outset to ensure there is a shared vision for service improvement and transformation. Equally important will be early staff, public and wider stakeholder engagement, particularly at a stage when there is a real opportunity for the outcomes to be influenced. This will help to ensure a shared focus on benefits realisation from the outset and collective agreement on a road map as to how benefits will be achieved.

It is vital not to underestimate the importance of a sound clinical evidence base and effective clinical leadership and engagement. Research suggests, for example, that the full benefits of transactions are unlikely to be met without effective clinical integration.⁴

Completing a governance review

It is perhaps tempting to assume that it will be easier to tackle governance challenges as part of the process of change. However, experience within the sector, particularly in those trusts that have been involved in major transactions, is that it is easy for boards to become overwhelmed by the volume of issues involved in organisational restructuring. It makes absolute sense therefore for boards to seek to check that their governance infrastructure and processes are working well before attempting to get to grips with the additional complexities and challenges of a new organisational form. We recommend that boards take the opportunity afforded by change to review the health of their governance arrangements, particularly their board assurance processes and the effective operation of the chain of accountability.

Assessing board capacity and capability

Having examined these structural and process issues, boards may then need to look at their own strengths as a team. Delivering the benefits of organisational change is as much about the calibre of leadership and direction as it is about the strategic planning capability of the organisation. The ability and credibility to lead the sort of cultural and behavioural changes required to improve care provision is not uniformly distributed across the sector and it is for each organisation to make its own judgments on whether it needs to strengthen its leadership capabilities prior to embarking on a programme of transformation. This is particularly important in the context of the need to continue to deliver business as usual.

The quality of board dynamics also need to be considered. Mature boards, where the expertise of non-executive directors is fully utilised, where all directors understand that reassurance does not constitute assurance, and where mutual challenge and support are normal practice, will be much better placed than their peers to tackle the additional governance challenges associated with change.

Conducting thorough due diligence

There has been speculation about the role that pre-approval or credentialing might play in facilitating a swifter process of organisational change, particularly with regard to acquisitions or instances where one organisation is exploring offering a management contract to support another organisation. Whether credentialing is pursued or not there is no substitute for thorough due diligence carried out for the specific transaction or change that is being considered. There is no one-size-fits-all here and there are no viable shortcuts. Boards would be unwise to rely on information that has been prepared for a third party because they will not have set the specification against which the information was gathered, nor will they have assessed the competence of those charged with carrying out research, so there would be limited assurance available to them. Nor can boards rely on

financial and legal advice that is not their own for the very reason that it is not theirs to rely on. In each instance, boards will need to set the parameters for historic due diligence and engage professionals that the board in question has confidence in and whose advice it is prepared to rely upon.

Establishing clarity of direction and control

It is vital that there is no ambiguity regarding how organisations or services are directed and controlled. While services may be delivered across systems, the players in such systems will continue to be organisations, answerable for what they have agreed to deliver and no more than that. Where there is no formally agreed, enforceable means of direction and control there is no control. Nor is there a continuum of accountability; the buck has to stop somewhere. It is vital for the organisation itself and for its stakeholders that there is clarity about who is responsible for delivery and that those responsible have the power to deliver and are held answerable for what they do. We will continue to work in a world of institutional accountability for the foreseeable future; one that is reinforced by a regulatory framework based on the same principles. It would be a mistake to think that there are informal alternatives.

Boards also need to be clear about the implications of partnership working. This is often referred to in anodyne terms such as pooling, but boards need to be clear that working in partnership involves ceding a degree of sovereignty and control. It is often the case that the benefits of partnership and devolution outweigh the dis-benefits associated with a diminution in the ability to effect speedy change, but this is a calculation that boards need to make consciously.

Finally boards should be wary about notions of 'pooled risk'. Clearly financial risk can be shared, but the damage to reputation should something serious go wrong will accrue to each of the partners in its totality and cannot be pooled. Organisations will therefore need to consider the extent to which there is risk to their reputations and the degree to which they can control such risks against the projected benefits of partnership arrangements.

Establishing local accountability

Alongside provider autonomy, local accountability arrangements are the key pillar of the foundation trust model. Any significant organisational change is likely to have logistical implications for the organisation of the council of governors, but more importantly for the successful operation of accountability relationships. Boards and councils of governors will need to consider the best arrangements so that governors can capture, understand and represent the interests of an increasingly diverse and geographically separated membership and general public.

Managing new risks

Organisational change clearly brings with it a change in risk profile that needs to be effectively assessed and mitigated against. For example, experience suggests that while companies formed to deliver services in partnership often flourish at the outset, they can become exposed if key personnel change or relationships breakdown. The importance of good relationships may seem obvious, but it shouldn't be taken for granted.

Recent NHS experience has also highlighted a tendency to underestimate the difficulties associated with dual running as major transactions take place. Monitor is also exploring instances where major transactions have thus far failed to deliver the benefits envisaged at the outset. It is important that as a sector we learn from the experience of those who have undertaken such transactions as well as from experience outside the sector in anticipating the risks ahead.

Some of the new organisations envisaged by Dalton and in the 5YFV could be larger than those we are most familiar with currently within the NHS. With scale comes increased complexity in delivering good governance. In this context the importance of diligent scenario planning should not be underestimated.

Securing high-quality assurance

That boards need to know their own organisations well is perhaps a truism. But one of the challenges posed by organisational change is assuming responsibility for services with which the board is not familiar. Lack of familiarity poses challenges for leadership and challenges in obtaining high-quality assurance. Boards will need to accommodate the implications of lack of familiarity into their planning processes.

Operating over a larger geographical area, with catchment areas which may not be contiguous, can make triangulation more difficult. Mental health and ambulance trusts have considerable experience to bring to the debate on organisational form given their familiarity with working across larger geographical areas and gaining assurance on services delivered from multiple sites and locations.

Agreeing dispute resolution mechanisms

Partnership arrangements leading to new organisational structures are often made possible by the existence of good working relationships. Notwithstanding that, disputes will occur, especially if things begin to go wrong. The more parties involved, the more likely that disagreements will happen and the more difficult they will be to resolve informally, so a good disputes resolution process that everyone signs up to early in the process is indispensable.

Securing appropriate independent advice

Most organisations that have been through a major transaction acknowledge the need for independent advice outside the due diligence process. It is essential to think through the purpose of independent advice. Independent advice can be targeted at the board as a whole to help guard against confirmation bias and group think while helping the board to be risk aware,

but not risk averse. Conversely it can be a source of support for individuals: the chief executive, the chair or for the director leading the change process. Advice from those with experience of the chosen organisational form would clearly be helpful, if it is available, but advice from organisations with recent experience of transactions of similar scale will be vital.

Future proofing

In the current NHS environment, future proofing is particularly challenging. However, building in a review process for governance arrangements will serve the dual purpose of meeting regulatory requirements and ensuring the organisation is sufficiently adaptable in its governance arrangements to accommodate future change. Boards should be conscious of the fact that such change might include withdrawing from the very arrangements that they are in the process of setting up, so an exit strategy should be part of the process from the outset.

The Dalton models

Having reviewed the overarching governance challenges that must be grappled with by any trust contemplating organisational change, this section now looks at the issues specific to each of the delivery vehicles included in the Dalton review.

Once again, what follows is designed to complement the practical checklists published by DH alongside the Dalton review, which highlight a wider set of issues that boards should consider and provide a reminder of the main approvals and legal questions that may need to be addressed.

Federations

Definition: Several organisations come together to collaborate to deliver one or more type of service or back office provision. Each organisation retains its sovereignty and there does not need to be a legal agreement. It is best practice for one trust or other body to be the nominated lead for governance, quality and finance, set out in a Memorandum of Understanding (MoU) or equivalent.

Potentially applicable to: All geographies and most local health economies (LHE) circumstances for sharing back office functions and performance improvement activities, significant sharing of clinical resources more likely to be limited to regional and contiguous. Unlikely to be a suitable response to serious financial difficulties.

Potential benefits: Sharing of best practice and alignment of patient pathways to improve outcomes and operational efficiency. Potential to share clinical resource and expertise and some back office functions to realise economies of scale.

Case studies: Academic Health Science Networks; Southern Sector Partnership in South Manchester.

(Extract from Pack A, *Collaborative Forms*, Dalton Review 2014.)

The main challenge in setting up a federal form of organisation is getting the governance between organisations right. While there are different degrees of federal structure depending on the degree of collaboration involved, all depend heavily on relationships that make the arrangements vulnerable to changes in personnel. As no one has yet reached an entirely satisfactory solution on this within the sector, it is an area that NHS Providers will continue to review in the year ahead.

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 that can impact on the reputations of each of the partners. Clarity about responsibility and lines of accountability needs to be settled from the outset. If the delivery vehicle is not an entity in its own right, all of the liability and all of the risk rests with the host organisation. If the delivery vehicle is an entity, typically a company that is wholly owned by the partnership and limited by guarantee, then that entity will have its own life and direction and a degree of control and sovereignty will in part be ceded to the new organisation.

Good governance between organisations means establishing from the outset what is in and what is out, how the new organisation will be directed and by whom, how disputes will be resolved and how individual partners can exit. If the new organisation is to be a company, the structure and shape of the partnership board will need to be agreed. The decision-making process will need to be agreed including what happens when there is dissent. How benefits and potential losses will be shared should also be considered from the outset.

It needs to be accepted by all parties that a new organisation will have its own plans and aspirations, and that the partners that established it will have a new role as owners rather than direct control. So as with any other relationship with an outside company, contracts will need to be in place for the services that the new organisation will provide. Finally, it needs to be understood that over time the new business could become a competitor of one or more of the founding organisations.

Joint ventures

Definition: Two or more organisations pool their sovereignty in either a corporate arrangement to create a new legal entity to manage a particular service line; or in a contractual arrangement to create a shared services agreement with another organisation.

Potentially applicable to: Densely populated areas where, subject to demonstrating patient benefit from increased scale and focus of JV, activity can be consolidated without significantly impairing patient access to services.

Potential benefits: Focus on managed services may lead to improved outcomes and operational efficiency. Access to skills and expertise of partner organisations and ability to separate risks borne by joint venture from partner organisations. Able to reinvest surplus directly into new equipment, upgrades and innovation if a separate corporate identity, giving staff greater feel of ownership over quality/cost improvement. Could be used to create a hub for developing specialist expertise that could give rise to a service-level chain. May help partner organisations to meet the quality standards over seven days through the pooling of the clinical workforce.

Case studies: South-West London Elective Orthopaedic Centre; Southwest Pathology; The Forum, Cambridge; UCLH Imaging Services

(Extract from *Pack A, Collaborative Forms, Dalton Review 2014.*)

NHS joint ventures have typically been formed for a specific and simple purpose, such as delivering a narrow range of products/services, so issues of control and direction are less likely to arise. As more complex ventures are considered the issues of ceded sovereignty, direction, drift in focus and reputational risk identified above will also apply.

Where joint ventures are designed to be profitable they can deliver dividends back to the owner organisations. Since dividends are not income from the provision of goods and services, it is likely that they will not count against the cap on the provision of services other than for the purposes of the NHS.

Management contracts

Definition: Some or all management control of the operations of an organisation is awarded to another organisation to manage for an agreed duration.

Potentially applicable to: Suitable for situations where poor clinical and/or financial performance can be transformed through change of control of some or all of the organisation's assets. These are time-bound arrangements with control being temporarily transferred to another organisation with sufficient management expertise and possibly some economies of scale. Not suitable where organisations are fundamentally unsustainable without major service reconfiguration in the local health economy.

Potential benefits: Asset light way to allow alternative providers to deliver services to a population. Access to previously unavailable expertise providing financial control, standardised processes, some consolidation of non-clinical functions. May address capacity or capability issues to allow focus on core site functions, or offer method of expansion through partnership with property or operating company.

Case studies: Hinchingsbrooke Health Care Trust, Ribera Salud Grupo, Valencia, Spain

(Extract from *Pack B, Contractual Forms, Dalton Review 2014.*)

Clarity about organisational objectives and timescales is particularly important here since the drawbacks and advantages of normal contractual arrangements apply: what is in the contract will get done, what is outside the contract will cost more. Contracts are relatively easy to terminate by both parties, which can be an advantage, but can create service continuity issues, so contingencies need to be in place.

The ability of boards to act decisively and autonomously is likely to be vital to dealing with long-term performance issues in a way that is sustainable over time. Furthermore the need for strong local accountability to build services that are responsive to local needs is unlikely to be enhanced by such arrangements. Current experience suggests that the NHS does not have a well-developed approach to

contractual arrangements. NHS organisations tend to default to a contract compliance approach to managing contracts as opposed to a partnership approach. This can lead to confrontation over specifics where dialogue and flexibility would be preferable. Finally, risk, both financial and reputational, is likely to accrue to the letting organisation, so it is even more important than usual that the costs and potential benefits are carefully assessed.

Service level chains

Definition: Some or all management control of the operations of an organisation is awarded to another organisation to manage for an agreed duration.

Potentially applicable to: Suitable for situations where poor clinical and/or financial performance can be transformed through change of control of some or all of the organisation's assets. These are time-bound arrangements with control being temporarily transferred to another organisation with sufficient management expertise and possibly some economies of scale. Not suitable where organisations are fundamentally unsustainable without major service reconfiguration in the local health economy.

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problems of management and governance, particularly in triangulation, obtaining assurance and ensuring strong lines of accountability. As the Nuffield Trust review found, experience in other sectors suggests that a key ingredient in the success of effective chains is clear processes in place for an internal quality audit, based on internal quality audit units operating at a national or regional level and sitting within the overarching corporate structure rather than being located in operating units.⁵

Service line chains may lead to tensions between the franchisor's business model, built on standardisation, and the desire in the franchisee to achieve its own identity and tailor services to the communities it serves. There may also be tensions between the need to engage staff in the design of local services and the capacity to improve and innovate against the requirement for consistency of approach. The tensions make the need for clarity of purpose and the need for thorough due diligence imperative.

“Service level chains could operate in two different ways: either as an outreach arrangement, where a trust simply uses another trust's premises to deliver a service; or as a contract, where a provider offers to supply a particular service or services to a range of trusts.”

Service level chains could operate in two different ways: either as an outreach arrangement, where a trust simply uses another trust's premises to deliver a service; or as a contract, where a provider offers to supply a particular service or services to a range of trusts. In both cases, lack of proximity brings its own

Integrated care organisations

Definition: Brings together some or all of the acute, community, primary care, social care and mental health services in a variety of forms. The organisation manages patients from a particular population across defined care pathways supported by shared data, IT and information systems.

Potentially applicable to: LHEs with a relatively large and well defined group of high-intensity service users have most potential benefits. Significant diversity of provider configurations, types of provider, contracting mechanisms and populations served means potentially applicable in any geography or LHE with sufficient potential to improve value for patients. Unlikely to be suitable response to short to medium-term financial issues given longer period to realise return as “integration costs before it pays” (Leutz, 1999).

Potential benefits: International examples have demonstrated improved patient outcomes and cost savings. Incentives such that care provided in most appropriate setting, focus on prevention and maintaining health, aligned patient flows.

Case studies: Integrated Care in Lambeth; Chelsea and Westminster Accountable Care Group

(Extract from *Pack C, Consolidation Forms, Dalton Review 2014.*)

Integrated care organisations (ICOs) may be formed as new legal entities as the result of a merger, or comprise more loosely configured affiliates with relationships between partners managed through contracts. Four main models are proposed in the Dalton report, each representing increasing degrees of organisational integration.

Forming integrated care organisations potentially simplifies the provision of care because the whole care pathway is controlled by a single provider. There is an early risk of managing and directing services with which the provider is unfamiliar and there may be financial risk associated with funding coming from multiple sources, but some of these risks will be offset by the diversity associated with a multiplicity of funding streams. There might be difficulty in securing payment in areas where secondary and tertiary providers have not traditionally offered services; in areas of primary care for example. It might also be difficult to secure the full cost of services that do not fit easily into current tariff definitions. Clearly early engagement with commissioners will be vital, but providers would also be best advised to build contingency into their business model.

In governance terms there are no specific challenges to controlling and directing an integrated care organisation formed via a merger other than novelty, which may have an impact on a board’s ability to obtain high-quality assurances in the short term. If the ICO is established via contractual relationships, the governance challenges highlighted above regarding management contracts will apply, including the need to establish a partnership approach rather than default to a contract compliance model if the ICO is to be sustainable over the longer term.

The impact of competition law on the viability of integrated care organisations is yet to be established, but in principle there is no reason why the need to provide integrated services could not outweigh competition requirements.

“Early engagement with commissioners will be vital, but providers would also be best advised to build contingency into their business model.”

Multi-site trust and multi-service chain/foundation group

Definition: Two or more organisations are brought together to become one organisation through merger; all the relevant organisations would dissolve and a new organisation would be formed. Alternatively, one organisation may acquire the other one, which dissolves and becomes part of the acquiring organisation.

Potentially applicable to: Currently exists in all geographical and LHE circumstances, though may not be clinically and financially sustainable in some areas without significant service change and/or diversification. Expansion largely relies on ability to consolidate services, having demonstrated patient benefits, may be better suited to urban and suburban areas.

Potential benefits: Possible economies of scale through service rationalisation and unified and support functions. Ability to move staff between sites to meet changing demand and share expertise.

Case studies: Royal Free London, Barts Health, Central Manchester University Hospitals

(Extract from *Pack C, Consolidation Forms, Dalton Review 2014.*)

The governance challenges for large multi-site trusts, multi-service chains and foundation groups as defined in the Dalton review are all amenable to being dealt with through a group structure. Whether that group structure includes a group headquarters and group management team with a group board supervising their work, or whether the structure is based around the existing board of one of the founding trusts, is very much a matter of local choice.

Multiple sites are a reality for the vast majority of providers. However, for most providers geographical proximity is not an issue and the size of their organisation does not raise questions about control and assurance. The Dalton review anticipates a number of

very large organisations perhaps using sites across the country. Very large, multiple sites trusts of this sort might need to consider whether they need to adopt a group governance structure.

In the private sector the classic group structure involves the group or parent company board overseeing the operation of the group as a whole at a strategic level, while the individual component companies of the group direct and control their part of business. A 'parent company' approach, where the board of the parent company sets broad group strategy as well as overseeing its own part of the business, would probably work best for foundation trusts.

There are options for governance arrangements below group board level. It would be possible to set up board committee arrangements sub and management arrangements to direct the subsidiary parts of the group. Alternatively the subsidiary organisations could be led by full boards. In either instance, clear schemes of delegation are vital.

A key advantage of each subsidiary organisation having its own board is that obtaining good assurance becomes a more manageable proposition. However, it does mean the parent board would need to cede large elements of control to the subsidiary boards. It would also require a different approach from Monitor because, while the legal entity would be the group, regulation would need to take place at subsidiary level. However, it is within Monitor's existing powers to accommodate this.

Whatever approach is taken there can only be one council of governors. In practical terms sub-sets of the council could operate in each organisation of the group. If the group goes down, the separate boards route these sub-sets could be responsible for reflecting the views of members and the public to the subsidiary board and for holding that board to account. The full council would then meet less frequently than is usually the case to work with the group board on strategy and group performance and quality.

Multi-service chain or foundation group

Definition: This model is distinct to a large merged organisation as it has a separate 'group' headquarters that sets the governance, standards, protocols and procedures, often with centralised procurement and back office functions. Each site is managed on behalf of the group by a management team that has delegated decision-making within the parameters set by the HQ board.

Potentially applicable to: All geographical and LHE circumstances including non-contiguous configurations. Dependent on the ability of the foundation group to replicate operational practices/standards on new sites and having the necessary capability and capacity to run services on distant sites. May be better suited than multi-site trust to acquiring new sites with limited potential for service rationalisation, probably less suitable for acquiring sites with significant financial problems and/or where the LHE faces fundamental problems.

Potential benefits: Improved quality and operational efficiency in new sites by standardisation and replication of proven operating frameworks, procedures and policies developed on existing sites. New sites benefit from strategic leadership, higher standards and support structures offered by the foundation group and may realise economies of scope through greater focus on operational management. May be possible for foundation groups to operate in situations that would be unsustainable for some standalone providers.

Case studies: BMI healthcare, Helios Hospital Group in Germany.

(Extract from *Pack C, Consolidation Forms, Dalton Review 2014.*)

“for most providers geographical proximity is not an issue and the size of their organisation does not raise questions about control and assurance.”

Next steps

There is a well-established consensus that new models of care are essential if the NHS is to deliver high-quality, more integrated services on a financially sustainable basis. What has been less clear is how this can be practically delivered. The Dalton review is an important step forward in outlining a range of organisational forms that might be adopted by NHS providers to effect this transformation.

This report has explored some of the governance implications of the seven different organisational forms that are proposed. As a number of the models have yet to be tested within the English NHS and applied within a foundation trust context, it is inevitably high level, designed to stimulate discussion and boardroom challenge as NHS providers consider their strategic options.

We believe it is essential that this support for trust boards is complemented by a concerted focus on the recommendations for system reform set out in the Dalton review. Both NHS Providers⁶ and the NHS Confederation⁷ will be working with system leaders over the coming months to ensure autonomous provider boards have the necessary flexibilities to meet local needs, backed up by robust accountabilities to their communities for their decision-making. We will also continue to work with the arm's-length bodies to ensure that NHS providers and commissioners are working together to operate within policy and regulatory frameworks which encourage more integrated care. This includes promoting proportionate, risk-based regulation, ensuring all trusts have a path to a sustainable future based on the principles of foundation trust status (autonomy and local accountability) and ensuring the competition framework and the transactions process do not act as barriers to the development of new organisational forms.

Further details on the NHS Providers and NHS Confederation programmes of work connected with the Dalton review can be found at www.nhsproviders.org/influencing-and-policy/five-year-forward-view/the-dalton-review and www.nhsconfed.org/health-topics/the-future-health-care-system/the-dalton-review

If you have any comments or questions on the content of this report, please contact john.coutts@nhsproviders.org, or for comments on any of our work related to the Dalton review, please contact amber.davenport@nhsproviders.org or francesca.reville@nhsconfed.org

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6. Please see NHS Providers' 'Programme for the Next Parliament' which sets out our 'asks' of the next government:
www.nhsproviders.org/resource-library/nhs-providers-programme-for-the-next-parliament
7. The 2015 Challenge coordinated by the NHS Confederation brings together 21 leading health organisations, including NHS Providers, to set out a common consensus behind the challenges facing the next government:
www.nhsconfed.org/~media/Confederation/Files/Publications/Documents/2015-challenge-manifesto.pdf

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The Dalton review was published alongside a set of supporting evidence packs and commissioned research. The key documents are available at www.gov.uk/government/publications/dalton-review-options-for-providers-of-nhs-care and are listed below. This section then goes on to highlight published research evidence on the organisational models discussed in the review.

Dalton review resources

- Methodology and engagement evidence findings
- Pack A: collaborative forms
- Pack B: contractual forms
- Pack C: consolidation forms
- Digest of reports
- Lessons from other sectors and international experience
- Monmouth partners: patient workshop findings for the Dalton Review
- Membership engagement services: Dalton Review survey of foundation trust members
- Nuffield Trust: provider chains, lessons from other sectors
- King's Fund: credentialing providers to take on additional responsibilities
- Foundation Trust Network: a review of buddying arrangements, with a focus on trusts in special measures and their partnering organisations
- RAND Europe: the changing hospital landscape: an exploration of international experiences
- Practical Checklists

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This publication forms part of a series of a joint programme of work by NHS Providers and the NHS Confederation which was commissioned by the Department of Health to explore the options presented in the Dalton review.



NHS Providers

NHS Providers is the membership organisation and trade association for the NHS acute, ambulance, community and mental health services that treat patients and service users in the NHS. We help those NHS foundation trusts and trusts to 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. NHS Providers has 226 members – 94 per cent of all NHS foundation trusts and aspirant trusts – who collectively account for £65 billion of annual expenditure and employ more than 928,000 staff.

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NHS Confederation

The NHS Confederation is the only body to bring together the full range of organisations that make up the modern NHS to help improve the health of patients and the public. We are an independent membership organisation that represents all types of providers and commissioners of NHS services.

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