

NHS Briefing: The Dalton Review Implications for providers



Introduction: The organisational toolkit

The recently published NHS Five Year Forward View¹ and Dalton review² mean that Boards of all NHS providers will need to rapidly consider the implications for their organisations, their response, and how to begin to reflect emerging policy on the structure of provision for NHS care in their strategic planning as clinically and financially sustainable organisations.

The NHS Five Year Forward View signals support for “a small number of radical new care delivery options” as well as “a whole system, geographically based intervention regime” for poorly performing health economies, while the Dalton review advocates an examination of current provider organisational form to “determine whether or not an alternative form would deliver better outcomes.”

Struggling trusts may need to consider their options under the new regime, whilst stronger trusts should also examine the risks and opportunities of their new position as “system architects”, encouraged to develop innovative organisational models and to codify and spread their success elsewhere.

The use of organisational form as a ‘solution of last resort’ within the NHS is familiar to most, although to date this has predominantly been in the form of mergers and acquisitions (M&A), usually in conjunction with fairly minor or no service changes.

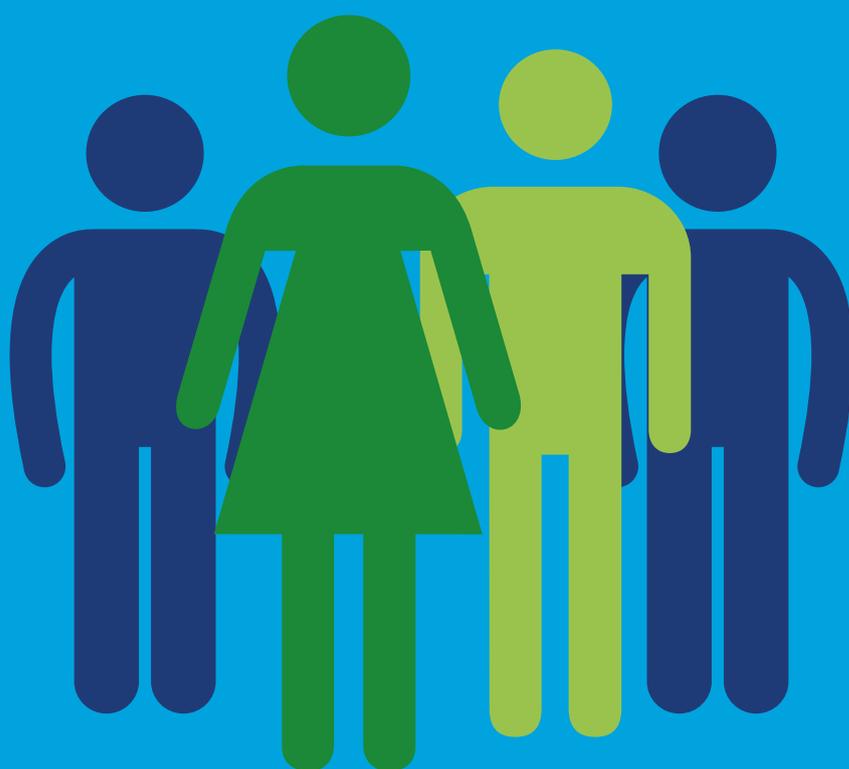
More recently, successful trusts have also started to independently consider whether coming together will help create the scale they need to ensure their clinical and financial viability in the longer term, for example the proposed merger between Ashford and St. Peters Hospitals NHS Foundation Trust and the Royal Surrey County Hospital NHS Foundation Trust.

However, what may be less familiar is the idea of organisational form as a ‘toolkit’ that can be used to remove barriers to collaboration and cooperation, enable successful implementation of service change, for example more integrated models of care, or to leverage strong leadership across a greater service footprint. Such a ‘toolkit’ (as described by the Dalton review) should be of interest to all NHS organisations in the current climate, regardless of their immediate challenges.

The ‘**organisational toolkit**’ encompasses a broad range of models that can be used at both a service and organisational level, in combination or alone; from shared budget arrangements, through different leadership models and on to more traditional organisational models like joint ventures, management contracts and M&A. It “complements the Forward View and provides the organisational ‘delivery vehicles’ that can help translate its ideas into reality”.

“England is too diverse for a ‘one size fits all’ care model to apply everywhere. But nor is the answer simply to let ‘a thousand flowers bloom’. Different local health communities will instead be supported by the NHS’ national leadership to choose from amongst a small number of radical new care delivery options, and then given the resources and support to implement them where that makes sense.”

Five Year Forward View



In this briefing we consider:

1. the lessons from recent transactions that trusts should consider in planning for any organisational change; 
2. how the approaches signalled by the NHS Five Year Forward View and Dalton review might work in practice; 
3. evidence for the different models; and 

4. the competition perspective, which although considered has received limited focus in the recent publications, with the Health Service Journal reporting that “the national leaders do not see competition – a hotly debated subject with public and politicians – as central to the forward view vision³”. 

To inform the briefing, we have **surveyed trusts involved in NHS mergers & acquisitions since 2010**, to understand the practical lessons learned to take into account in moving to new organisational models.

What we have learned – in brief

Summary of proposals	Key considerations	Our view
<p>The Five Year Forward View and Dalton review recommend exploration of a number of new service and organisational models that could deliver better outcomes for patients of the NHS.</p> <p>Some of these models cross existing organisational boundaries (to promote more integrated care) or geographies (to promote the spread of best practice).</p> <p>Rapid mobilisation is advocated through a “special measures” or “success” regime for struggling health economies, the fast track procurement of NHS Trusts requiring a management contract or acquisition to ‘kitemarked’ organisations and encouragement of successful organisations to act as ‘system architects’ by road-testing innovative new forms.</p> <p>In support of this it is recognised that quicker and more aligned regulatory processes for ‘transactions’ are required.</p>	<p>There is limited evidence for some of these new innovative forms in the UK, particularly hospital chains and integrated care organisations.</p> <p>Our survey of recently merged organisations shows that leadership, organisational culture and stakeholder support are the key determinants of success – this is likely to be equally applicable to all organisational forms.</p> <p>Running your own organisation successfully doesn’t necessarily translate into an ability to leverage systems and processes across multiple sites or providers and many system leaders believe that the NHS is not yet geared up to support cross health economy management.</p> <p>The proposed approaches will require a fundamental shift in mind-set and risk-appetite for some NHS Boards, at a time when significant financial and operational pressure is forcing many management teams to focus inwards.</p>	<p>Whilst pilots will quickly follow, there is unlikely to be rapid and large scale implementation of the more innovative forms such as multi-service chains until there is a greater body of evidence.</p> <p>Simple one to one acquisitions, management contracts and buddying are likely to be the primary organisational form mechanism to address failure, due to their relative ease of implementation. Management contracts may be particularly attractive as a lower risk and potentially quicker solution, in some cases as a pre-cursor to a merger.</p> <p>However the NHS cannot afford to stand still. The ‘organisational toolkit’ proposed by the Dalton review offers a potential route to support the ambitions of the Five Year Forward View and the financial and clinical sustainability of individual providers. As a result the Boards of NHS Trusts and Foundation Trusts alike will rapidly want to consider the implications of these emerging policies for their organisations.</p>

Lessons from recent NHS transactions

To draw lessons for the trusts planning for new organisational forms, we have reviewed the pre and post-merger performance of a number of NHS mergers & acquisitions from 2010 to the present date and posed key questions to the past and current management of these organisations.

As the most prevalent form of organisational change in the NHS, and for many years the default option to deal with financial failure, a broad body of evidence exists for multi-site mergers and acquisitions.

Many health commentators have claimed that the evidence for mergers & acquisitions is limited, often failing to achieve their stated objectives (Gaynor *et al* 2012)⁴ and that it is unequivocal that the risks from full scale organisational change are high (Kings Fund, July 2014).⁵ However, the past studies on which these conclusions are based have focused solely on transactions pre-2010, and do not therefore consider those undertaken during the current regulatory regime which has led to a significant step-up in planning and preparation.

In the context of the continuing support for mergers & acquisitions in the NHS, we were therefore particularly interested in the lessons learned from transactions over the past 5 years and in whether these experiences lend any further support to the continuing use of transactions either as a route for dealing with failure or to ensure the long term success of stronger organisations.

Deloitte examined the pre and post-merger performance of a number of NHS mergers & acquisitions from 2010 to the present date and posed some key questions to the past and current management of these organisations.

Figure 1. Position of mergers since 2010

Enlarged Trust	Transaction	Date	FY13/14 Operational performance*	FY13/14 Financial performance*	Current Monitor risk rating [^]
South Essex Partnership University NHS FT	Acquisition of Bedfordshire & Luton Mental Health NHS Trust	Apr-10	●	●	4
Hampshire Hospitals NHS FT	Basingstoke & North Hampshire NHS FT acquired Winchester & Eastleigh Healthcare NHS Trust	Jan-12	●	●	2
Barts Health NHS Trust	Barts, Newham, Whipps Cross NHS Trusts merger	Apr-12	●	●	n/a
Southern Health NHS FT	Acquisition of Oxfordshire Learning Disability NHS Trust (Ridgeway)	Nov-12	●	●	3
South Western Ambulance Service NHS FT	Acquisition of Great Western Ambulance Service NHS Trust	Feb-13	●	●	4
Lewisham and Greenwich NHS Trust	Lewisham Hospital NHS Trust acquired Queen Mary's Hospital Woolwich	Oct-13	●	●	n/a
Kings College Hospital NHS FT	Acquisition of Princess Royal University Hospital	Oct-13	●	●	3
Oxleas NHS FT	Queen Mary's Hospital, Sidcup (site management)	Oct-13	●	●	4
Royal Free Hospitals NHS FT	Acquisition of Barnet and Chase Farm Hospitals NHS Trust	Jul-14	●	●	3

2010

2014

● Worsened ● Too early ● Improved ● No change

* Our assessment of changes in operational and financial performance from last reported results pre-merger to 13/14 reported results based on publicly available information
[^] Monitor COSRR and Governance Risk Rating at 19th December 2014. Grey represents governance risk rating under review

Note: Publicly available information, excludes TCS transactions due to difficulty measuring pre-transaction performance



The results suggest an improvement or no worsening in around half of situations reviewed, which is significantly better than that observed in prior studies (Gaynor et al, 2012, which then observed no productivity improvement in 102 of the 112 acute hospital mergers between 1997 and 2005 and no improvement in financial position). However, the assessment is limited by the relatively small number of transactions during this period, the difficulty in disentangling the changes brought about from M&A versus other changes in the health economy and understanding how the acquired organisation might have fared alone, and that we have not undertaken a comparison of equivalent organisations that have not undergone a merger.

A number of clear themes were apparent from the responses received from NHS organisations and should be considered by organisations considering any change in form:

Objectives

What were your key objectives in undertaking the merger or acquisition?

The majority of respondents cited **“increase in market share”** a **“defensive strategy”** and **“clinical scale”** as their primary objectives for merger. Respondents expressed a desire to **“strengthen resilience and the organisational capacity and capability”** of both their home organisation and the acquired site(s). Additionally, a responsibility to patients and the public, in particular where the acquiring Trust was the only interested party, was widely cited.

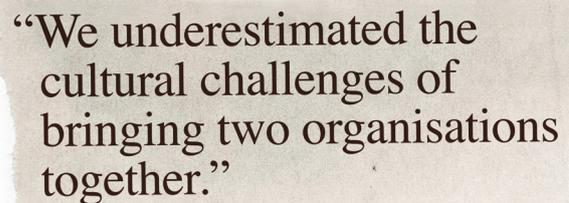


...we felt that we could improve things a lot for a patient catchment that overlapped with ours, and that therefore we should do that...”

Key challenges

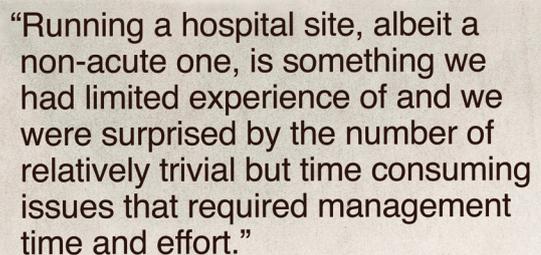
What are the key challenges that you faced, and how did your view of these challenges change post-merger?

Many respondents felt that they had underestimated the challenge of cultural differences going into the transaction. Even in those mergers that appeared to be successful, based on measures of performance, managers felt that the cultural differences between sites were still very apparent several years post-merger, with resistance to change being a key barrier, particularly in acute trust mergers.



“We underestimated the cultural challenges of bringing two organisations together.”

The loss of key people during merger left some trusts **“devoid of leadership and organisational memory”**. This was a particular challenge for organisations acquiring services outside of their usual portfolio.



“Running a hospital site, albeit a non-acute one, is something we had limited experience of and we were surprised by the number of relatively trivial but time consuming issues that required management time and effort.”

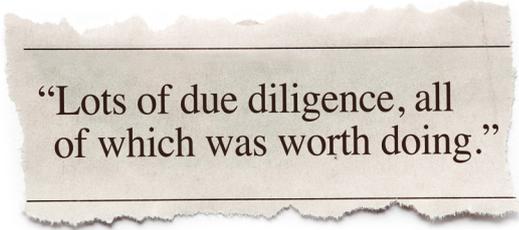
Respondents described external influences, such as commissioning plans and regulatory demands, as “threats” to the stability of newly formed organisations. The latter in particular dictated the pace of change and didn’t give trusts the “headroom” required to transform the acquired organisation.

Respondents warned against underestimating the costs of merger, both in terms of aligning organisational structures (service models, IT, estates, etc.) and the significant drain on management “time and effort”.

Planning

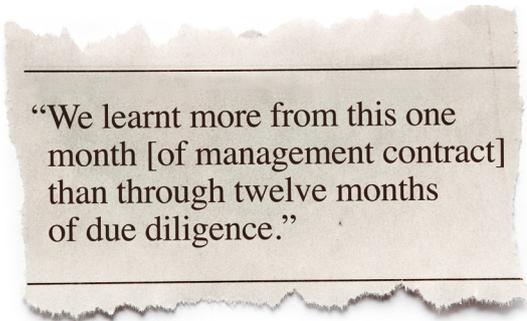
What level of planning did you undertake for the merger, and how do you think this could have been strengthened in hindsight?

All respondents had undertaken what they felt to be a significant level of planning, including a full post-merger integration plan and due diligence. However, most were caught unawares by some significant issues, frequently around the condition of property. There was a strong sense that when you lift the lid “you just find stuff” with one respondent stating “to say we inherited a bit of a mess is a massive understatement!!”



“Lots of due diligence, all of which was worth doing.”

On further examination, it appears that in some cases planning was more detailed for corporate services than clinical services, which has had some bearing on the success of realising planned benefits. Another observation is that an over-reliance was placed on desk-based due diligence versus detailed operational research by Trust managers on the ground. This has also been seen in other significant service changes, such as trusts taking on retendered community services. While desk based due diligence was widely felt to be essential, some respondents talked positively about road testing operational management of the new site through a secondment or limited time period management contract.



“We learnt more from this one month [of management contract] than through twelve months of due diligence.”

With hindsight respondents felt that more attention should have been paid to the “softer challenges of integration” in planning and preparation, in particular to aligning often divergent cultures.

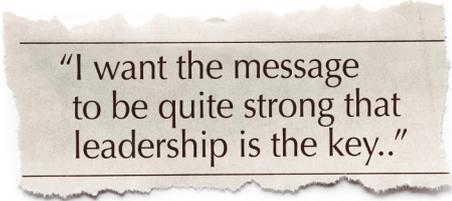
What were the biggest surprises you faced post-merger?

The biggest surprise for many respondents was the difference between planning and reality. “...we could not have known the detail of that until we took over”.

Resources

What level/type of resource (people and financial) did you have to support integration and was this sufficient?

The level and type of resource varied significantly – some respondents had significant external support (consultancy, lawyers, specialist advisors) or created new transitional roles to manage the transaction, while others managed the transition with existing staff. Respondents’ views on whether support was sufficient were also mixed. Some felt the support was sufficient, while others felt much more was needed. One respondent even felt that the trust should have “doubled up” on leadership even beyond the start of the new entity.



“I want the message to be quite strong that leadership is the key..”

Only one respondent mentioned financial support, but others warned to “build in enough financial contingency, as there will always be hidden costs”.

However, overall respondents stressed the importance of “getting the level of support right post-merger”.

Delivering the benefits

Have the benefits set out in the business case been delivered/are on track to deliver and if not what have been the key areas of challenge?

For many respondents it was **“too early to say”** whether benefits set out at the start of merger had been delivered. Some were seeing early positive signals (improved A&E and RTT performance). For others there were unexpected challenges post-integration (estates maintenance backlog, delayed redevelopment, delayed decision-making), which make it hard to determine whether the merger was a success or not. With hindsight, some respondents felt that their plan for the speed at which benefits could be realised, particularly in clinical services, was too ambitious.

Many respondents described system challenges rather than organisational ones – balancing the demands of transition and transformation with the **“scrutiny of multiple assessments”** and **“conflicting commissioning plans”**.

Culture

To what extent have staff behaviours been a barrier to change post-merger and what tactics have been most successful in addressing this?

Some respondents described challenges with **“harmonising culture”** between staff groups, particularly across geographically dispersed sites. They described a **“resistance to change”** among change fatigued staff. Trusts employed a range of techniques to engage staff, from restructuring divisions and site rotation to drop ins and surveys, but all respondents cite communication throughout and post-merger or acquisition as key – **“keeping staff informed throughout and to involve them in plans where possible”**.

Some respondents were pleasantly surprised by staff behaviours post-merger – however, it is difficult to know whether this was a direct result of the tactics employed or other factors.

Top tips

To conclude the survey we asked all respondents what top 3 tips they would give to an Executive team entering into a merger. The three critical success factors that came up most frequently in responses were **stakeholder engagement, due diligence and external support**.

Engagement with internal and external stakeholders was seen as fundamental to the success of M&A.

Respondents described the importance of ensuring that staff are well informed and involved throughout and post-merger, commissioners understood how the proposition helps them strategically and that communications are **“consistently, joined up and timely”**.

Respondents stressed the need to **undertake detailed Due Diligence** and for that to be coupled with on-the-ground experience of operational managers to inform the heads of terms and help minimise any surprises post-merger.

One respondent stressed that the heads of terms needed to be agreed as early as possible to **“promote transparency and trust between parties”**.

Respondents stressed the importance of **“getting the level of support right post-merger”** and suggested that this was an area where executives should **“invest for success”**. Support from regulators in terms of negotiating the breathing space required to transform underperforming organisations was seen as essential.

“Relationships are the most important thing to get right.”

How the proposed approaches might work in practice

Below, we look at the key considerations for implementing the approach to identify the best fit future organisational forms for providers, as set out in the Dalton review, as well as the health economy special measures regime proposed by the NHS Five Year Forward View.

Key considerations for potential organisational form changes

It has been clear for some time that an alternative approach will be required for many of the remaining 93 NHS Trusts, given the underlying implication that there is some reason preventing their achievement of Foundation Trust (FT) status. There is a growing consensus that many are unlikely to achieve FT status within their current system configuration, i.e. by trying to address the issues internally without adopting major service change within their local health and social care economies.

Given the existing system issues, coupled with increasing clinical and financial pressures within the NHS, the search is on for ways in which these trusts, together with equally struggling FTs, can be supported.

In February 2014, the Department of Health announced a review by Sir David Dalton into new organisational forms for the provider sector, initially expected to focus on acute hospital chains and the barriers to their implementation. However, in practice the Dalton review, published in December 2014, has looked at a much broader spectrum of options (the 'organisational toolkit') including **collaborative forms**, such as federations and joint ventures; **contractual forms**, such as service level chains and management contracts; and **consolidation forms**, such as single and multisite trusts, multi-service chains and vertically integrated care organisations; as well as other models such as buddying, learning and clinical networks.

This is in line with the growing view that there is no "one size fits all" solution and that any clinical and organisational solution needs to be locally developed, and may involve the implementation of more than one organisational form in any organisation.

An interesting and key recommendation of the Dalton review is that the remaining NHS Trust pipeline should be categorised into those that can reach FT status and those that require a different organisational form to be sustainable and that a trajectory and milestones should be developed to support this. The categorisation is likely to include standalone FT, FT with buddying support, management contracts or acquisition by alternative provider(s). This differs from the previous FT tripartite agreements (3-way agreements between trusts, Strategic Health Authorities and the Department of Health on milestones to reach FT status) in that it is likely to be more criterion driven and led by regulators rather than Trust Boards.

Central to the proposed approach is that a number of organisations (primarily FTs) nationally would be credentialed or given a 'kitemark' for each route, so that when the future form of an individual trust is identified, a fast track solution can be implemented quickly and will enable the required service change. It is expected that Monitor will be responsible for this process and the first wave of credentialing will be completed by October 2015.

Kitemarked trusts would be able to register for management contract and acquisition opportunities and would automatically pass the Pre-Qualification Questionnaire (PQQ) stage of any tendering process. Another proposal is that acquiring trusts should be granted a "grace period" with an agreed trajectory for improvement, which will be separate from the overall performance of the combined organisation.

Where a transaction is envisaged we understand that it is proposed that this will be accompanied by independent due diligence, a financial package (to be determined by the due diligence process) and "tender prospectus" to enable negotiations to focus on the proposed solution.

In our experience, to achieve a successful transaction in such circumstances it will be critical to gauge the market interest and pitch the funding package at the right level to attract potential partners and enable the resulting enlarged organisation to succeed. Such considerations are likely to be equally important in executing any management contract.

“Build in enough financial contingency, as there will always be hidden costs. Get the level of support post-merger right.”

Acute Trust transaction Senior Responsible Officer

This proposal opens up a number of questions, including how the NHS Trusts will be categorised, how FTs will be credentialed as part of the solution and what the impact of competition regulation will be, which may make the practical implementation of the proposals more challenging.

Another suggestion of the Dalton review is that the NHS Trust Development Agency (TDA) could run batched procurements to fast track solutions for groups of particularly challenged trusts that will require acquisition or contractual solutions. This is expected to lead to more innovative solutions, for example FTs forming joint ventures with other FTs or the independent, voluntary, or social care sectors, in order to run a number of management contracts.

Criteria for NHS Trust categorisation – Publication of the TDA’s categorisation of NHS Trusts (as recommended by Dalton) has the potential to be controversial, with some Boards not wishing to accept support, and keen to retain control of their own destiny. A robust and evidence based assessment that can stand up to scrutiny will be essential.

In our view, this is likely to include an assessment of whether the NHS Trust can be viable in its current configuration (those that can’t will require a health-economy-wide solution), whether existing management is capable of leading the organisation through the required change, whether there are any nearby successful organisations that would be capable of taking on the NHS Trust’s services (subject to credentialing), and local political factors (e.g. a history of failed mergers or difficult relationships in the local health economy). These are difficult judgements to make, but successfully doing so will be key to any assessment criteria, with the critical objective being to arrive at a proposed future for each NHS organisation that is both sustainable and can be delivered.

“We had underestimated the impact of culture, it has been the most important and challenging aspect of the integration”

Criteria for FT credentialing – In our view, and supported by our survey of leaders of recently merged organisations, leadership capacity, including on the ground involvement of senior clinicians and addressing cultural differences is the biggest pre-determinant of success in implementing change, and is therefore likely to appear firmly in the credentialing criteria. The 2014 King’s Fund report on credentialing, undertaken as part of the Dalton review,⁶ suggests that the most important assessment criteria are:

- leadership
- organisational culture
- people management and staff engagement
- improvement capacity and methodology
- innovation
- governance
- quality and financial performance
- partnership working and system leadership
- track record in M&A or turnaround

Areas to consider in any assessment include elements of the 'Well Led' framework, staff survey results and the views of clinicians and other staff, alongside looking at the organisations current cross site working practices and financial, clinical and operational performance.

However, being able to run one's own organisation does not automatically translate into being able to leverage systems and processes across multiple sites/providers, and it is difficult to see how this can be assessed, given the limited experience of any UK health management teams in running multiple businesses outside of the private sector. It is likely that the suggested criteria would need to be extended and adapted in order to evaluate an organisation's ability to run a chain or franchise.

Key considerations for a health economy "special measures" regime

Now being termed a "success regime", the Five Year Forward View suggests creation of a health economy "special measures" process that directs struggling areas quickly into new care models.

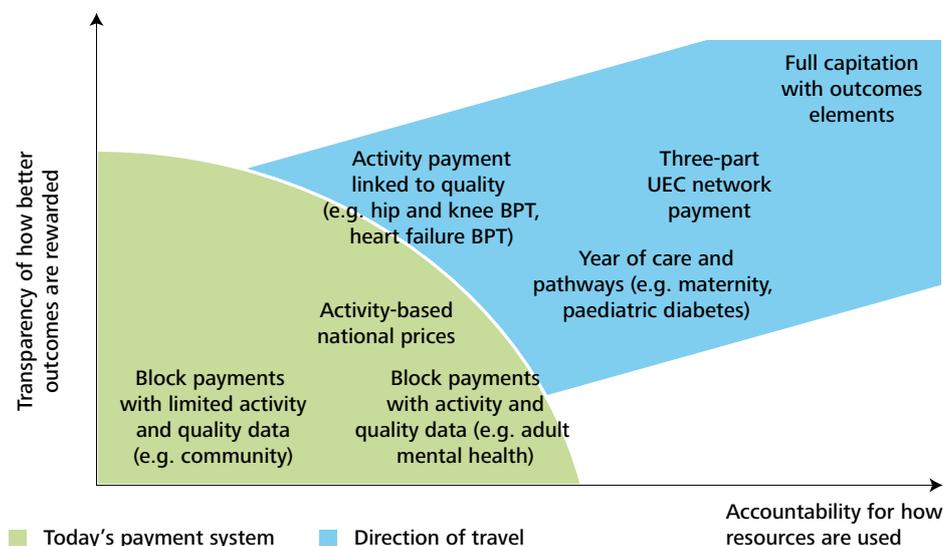
Our experience of the type and scale of service redesign that is likely to be needed in health economies requiring a "special measures" solution, is that it requires considerable commitment from the leadership of individual providers to a shared vision of care in the local health economy that may leave their individual organisation worse off. These often fragile partnerships can be derailed by many things, not least a regulatory approach that is focused on the performance of individual organisations alone.

Whilst legislation gives NHS England, Monitor and the TDA responsibility for specific organisations – and there is no indication that this will change – over the past year they have developed informal arrangements to work together at national and regional level, in particular in attempts to closely manage hospital waiting times performance and in addressing the problems of 11 challenged health economies for which they jointly sponsored intensive planning support to develop a solution.

In practice we have seen this approach has tended to comprise aligning messages from the three regulators to the local health economy (LHE) and joint monthly progress checks between the regulators and the LHE partners. This 'singular joined up national oversight'⁸ has received positive feedback from the LHE leaders involved in these reviews.

Going forward we believe the proposed "special measures" style designation (or "success regime") is likely to build on this approach in a more formalised way, perhaps requiring joint regulatory sign up to health economy wide recovery plans, a joint package of transitional funding to support change, a pre-agreed "period of grace" on targets for organisations in a transitional phase (such as is offered by Monitor to FTs post-acquisition and proposed by Dalton) and perhaps the delegation of part of the regulators powers to one authority to 'manage' the system during special measures.

Figure 2. Payment system changes⁷



The 'organisational toolkit' is also a key lever to break down barriers to health economy change, whether this be through a capitated budget for a whole health economy, such as that seen in Accountable Care Organisations in the US, or through formal collaboration at a service line level, such as envisaged by Dalton's service level chains.

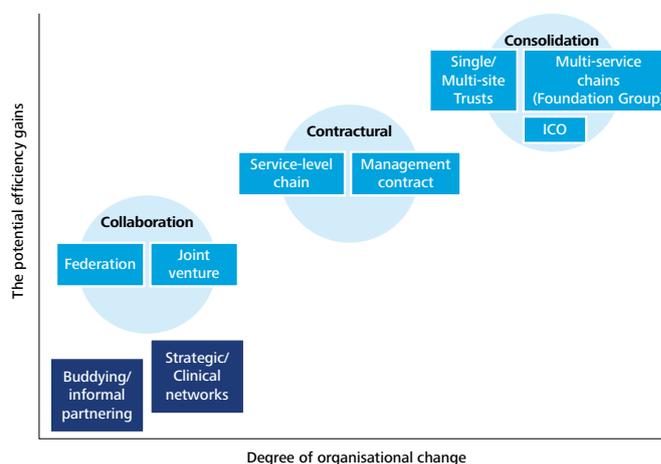
In our view, it will be equally important to develop new payment and risk/reward sharing mechanisms outside of tariff to enable major change to be undertaken without destabilising individual organisations, or (in particular for NHS Trusts) driving them unnecessarily down an organisational form route when essential elements, like leadership and organisational culture, may not be sufficiently aligned to allow this to succeed. NHS England and Monitor have started to develop a set of payment approaches designed to support the rapid shift to the models described by the Five Year Forward View and Dalton review by 2020. These approaches are a blend of activity-based, outcomes-based and capitated payment mechanisms designed to increase both transparency and accountability.

The different models

It is helpful to think about the spectrum of organisational models and other levers for change in the 'toolkit' against the, by now familiar, perspectives of 'level of organisational change' and 'level of control ceded'⁹. At the lowest level, organisations can collaborate without significant change or control ceded, e.g. buddying, whilst at the most extreme level an organisation taken over, merged or absorbed into a hospital chain, fully cedes control. The Dalton review adds the additional perspective of 'potential for efficiency gains' into its assessment of organisational models.

There is limited evidence at present for many of the potential provider forms mooted, at least within the UK, because of the limited current use of these organisational forms. That said, there are more examples of clinical networks, joint ventures and other types of collaboration 'under the radar' in the NHS than is immediately apparent and in many areas local government has been at the forefront of considering innovative structures and alternative delivery models (such as mutuals and social enterprises) that could have applicability in the NHS. Our work with the NHS and local authorities has brought us into contact with many of these.

Figure 3. Organisational toolkit¹⁰



Collaborative forms

Buddying – This is a relatively new approach where trusts in special measures are partnered with a high performing organisation that provides leadership support without any delegated decision making powers. The buddy organisation is selected by Monitor or the TDA for its strength in areas where the trust in special measures has weaknesses. One risk raised around this arrangement is that the standards in high performing hospitals could fall if its leaders are distracted and, whilst some trusts have spoken positively about their experiences of buddying¹¹, others have told us that the depth of their buddying relationship was limited by fears of reputational impact at the buddy trust.

The Dalton review recommends that the current buddying system should be expanded, beyond the special measures trusts, into a partnering system to allow organisations with the potential to improve early access to support and guidance from credentialed organisations, with clear arrangements to identify and remunerate trusts capable of providing support.

Buddying relationships can be a positive experience, but trusts can have concerns over the risk of reputational damage from the performance of the trust they are working with.

Networks – Learning networks are loose affiliations designed to expose staff to best practice ways of working, for example through shared training, and are a key function of the 15 Academic Health Science Networks (AHSN) established by NHS England. More formal hospital and managed care networks aim to improve the quality of care and drive more cost effective deployment of resources. They are likely to align policies between institutions, but they do not create new integrated delivery structures. Evidence suggests that existing networks in services such as stroke, cardiac and cancer services improve quality,¹² whilst the Five Year Forward View envisages Urgent and Emergency Care Networks which link hospitals to ensure patients with the most serious needs are treated in specialist emergency centres. Our experience working with acute hospitals has shown that networks can also offer practical benefits through the use of joint appointments and information sharing creating a ‘win-win’ situation. However, they are unlikely to deliver major service changes.

Federations – In federated arrangements each organisation is able to retain its independence while collaborating with two or more organisations to deliver specific services or back office functions or improve performance. There does not tend to be a need for a legal agreement, although one trust may take a lead role for governance purposes. Federated models offer the opportunity to share best practice, align patient pathways and deliver quality and cost improve improvements through economies of scale. Examples include the Academic Health Science Centres (AHSC), including King’s Health Partners delivery of IMPARTS to integrate mental and physical healthcare in research, training and clinical services¹³ and UCL Partners’ work on the stroke pathway.¹⁴ Similar to Networks, they are unlikely to deliver major service changes and their aspirations are sometimes limited by ‘politics’ between organisations.

Joint ventures – These arise where two or more organisations form a new structure to provide services. This can be a new legal entity with shared equity and governance arrangements (corporate joint venture) or where one organisation acts as the host provider and takes responsibility for governance, quality, performance and financial reporting (contractual joint venture). The joint venture (JV) can relate to back office services, clinical support services or a whole patient pathway and encompasses some models of Accountable Care Organisations seen in the US.¹⁵

JVs in particular offer solutions to trusts in geographical proximity through the creation of single shared services that enable workforce to be consolidated across organisations – particularly pertinent in the context of national workforce shortages and the need to meet demanding service standards for emergency surgery and acute medicine across seven days.

Examples of where JVs have offered benefits include the south west London elective orthopaedic centre, which has been able to standardise care pathways, pool clinical expertise and generate savings through a joint procurement, and pathology JVs including Viapath in south east London. However, JVs do have a tendency to be unstable, and we have seen many arrangements end due to partner dissatisfaction with the quality of outsourced service provision.

Contractual forms

Single-service level chains – This is a contractual form, similar to a JV, where one provider delivers a service or specialty from premises owned by another provider. This is often known as the ‘at’ or @ model and could be considered as a host provider ‘outsourcing’ their activity. Contractually service-level chains can take many forms, but they are considered most suitable for stand-alone specialisms, ambulatory care and certain imaging-heavy specialities that can be delivered remotely.

This may be particularly relevant for small hospitals where some specialist services might be provided by other providers on its sites, such as the model developed by Moorefields Eye Hospital where they deliver satellite clinics at other Trust sites. Other services that have utilised or are considering this model include cancer, radiotherapy, neurosciences, paediatrics and ophthalmology. Challenges include developing clinical governance and risk policies, particularly when patients move across into other services, e.g. critical care. It would therefore be unsuitable to adopt for a service which has multiple connections with the rest of the hospital, e.g. A&E.

Management contracts – Taking the concept of buddying and networks a step further, a management contract allows the management of one organisation to deliver part or all of the services of another organisation, for a time specified period.

The model includes both ‘management franchises’ where the management provider takes over the management of a trust and ‘operational franchises’ where the provider takes on day-to-day responsibility for operations and finance, such as Circle’s management of Hinchingsbrooke (the only full hospital example in the UK). Circle’s recent announcement of its intention to withdraw from this arrangement due to the financial sustainability of the contract terms will deliver a blow to the concept and to other trusts, like Peterborough and Stamford NHS FT, potentially considering replicating the model.

Circle’s withdrawal from the Hinchingsbrooke Management franchise is a major blow to the concept.

While in the past ‘management franchises’ have sometimes been utilised as a short term arrangement on route to a transaction, they are now being advocated as a longer term intervention in cases of poor performance in order to drive through improvements. One attraction of this is that it provides a quick route to provide management expertise to struggling trusts. Trusts get help without losing their organisational identity and it may be seen more positively by staff than some alternatives. For FTs considering such an arrangement, it is potentially a lower risk way to expand their geographical reach and many will see such an arrangement as a precursor to a potential merger. Considerations include procurement requirements, the level of control (e.g. over Board decisions, or going as far as appointments of Board members), clear lines of governance, performance requirements, financial statements consolidation and ability to exit the contract. One important factor to consider is the level to which the management provider is able to make changes that integrate service provision across organisations, given the potential for the arrangement to end, and whether the change of control gives rise to a material lessening of competition.

Consolidation forms

Integrated Care Organisations

Within health economies Integrated Care Organisations (ICOs) may be a solution to address the challenge smaller organisations face to become an FT or as a mechanism of aligning incentives across acute/community organisational boundaries. However integrated care can be delivered through a virtual (contractual) vertically integrated model as well as a formal (consolidation) route.

The ‘virtual’ model can be supported by alliance contracts across providers or a prime/lead provider model where the commissioner contracts with one organisation which sub-contracts with other providers. One example of this is the Primary & Acute Care System (PACS), which vertically integrates services across list-based GP and hospital services, plus mental health and community services. At their most radical, PACS would take accountability for the whole health needs of a registered list of patients, under a delegated capitated budget – similar to the Accountable Care Organisations that exist in the US and elsewhere.

The ‘formal’ ICO involves the vertical integration (through M&A) of one or more providers that could include primary, secondary (acute and mental health), community and social care. These are population based and deliver services to a defined cohort of patients with the aim of improving their outcomes. This could include the new option of the Multi-specialty Community Provider where extended group GP practices form – either as federations, networks or single organisations – and could take on the running of the main acute or community hospital and have delegated budgetary responsibility for their registered patients. There is limited evidence for ICOs in the UK at present, although interest is increasing and new models and pilots rapidly emerging. Considerations include how the Board can ensure sufficient expertise within management and a likely requirement for significant investment, particularly in IT, to deliver savings. Changes to the way services are funded is also likely to be a critical enabler.



Multi-site trusts – A multi-site trust is the most common organisational form for larger organisations in the NHS and occurs where, through a series of transactions, one provider owns and operates a number of hospital facilities in close geographical proximity.

There are potential synergies that can be realised through the merger or acquisition of nearby organisations. However, many studies¹⁶ (primarily of mergers pre 2010) have shown them to be of limited value in delivering planned improvements.

Our more recent experience includes advising on the disposal of South London Healthcare NHS Trust to a number of receiving organisations, the disposal of Barnet and Chase Farm Hospitals NHS Trust to the Royal Free NHS FT and the potential acquisition of West Middlesex Hospitals NHS Trust by Chelsea & Westminster Hospital NHS FT. This experience has shown us that most benefits tend to arise from economies of scale in management and back office, with clinical benefits arising from the consolidation of services onto a single site or through joint rotas especially given the seven day working agenda. Significant investment in integration, including IT infrastructure, is typically required.

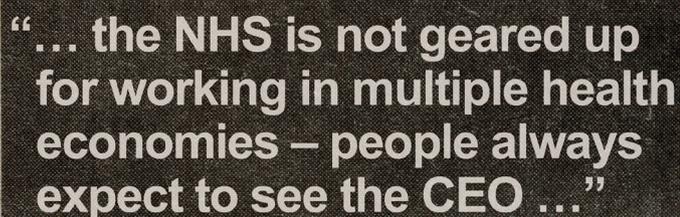
In our view, informed by our study of transactions post 2010, the critical success factors for multi-site trust mergers include a clear rationale and business case which articulates the clinical and financial benefits, a detailed implementation plan with a strong governance and accountability framework as well as, crucially, the right leadership and culture to deliver these plans.

Hospital chains or foundation groups – Also described as ‘geographically dispersed multi-service line chains’, are a further step beyond a multi-site trust created by an acquisition, multiple simultaneous acquisitions or the merger of two large multi-site trusts to form a new group. In the model, one provider owns and operates a number of separate subsidiary sites across a dispersed geographical area. Chains have separate group headquarters (HQ), which set standards, protocols and procedures with centralised management and procurement functions. All sites in the chain are managed on behalf of the group by a management team that have delegated decision-making responsibilities within the parameters set by the HQ board.

While the model dominates the private hospital market, there are extremely limited examples in the NHS, with senior leaders citing a degree of scepticism about the NHS’s ability to apply systems and processes uniformly and exercise such a large span of control, particularly in the situation where an acquired trust is failing.

Some FTs are considering the concept of a hospital chain or group of highly performing organisations, that once established would have the increased management capacity through its group structure to deal with more challenged acquisitions.

Hospital chains are much more prevalent overseas, particularly in the US and Germany, but evidence for their success is mixed, with many observers drawing the conclusion that the key factors of success are cultural rather than specific to any one model.



“... the NHS is not geared up for working in multiple health economies – people always expect to see the CEO ...”

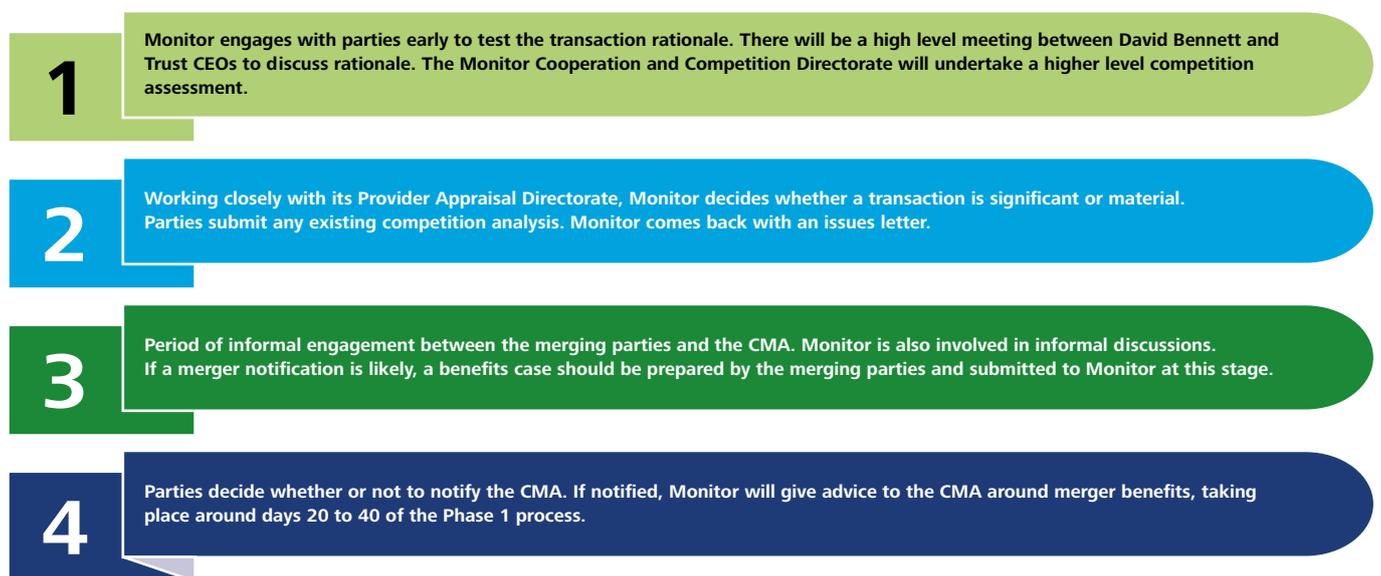
Merged Trust CEO

The competition perspective

The approaches to driving service and organisational change described in the NHS Five Year Forward View and Dalton review, have multiple implications for competition regulation, in what is already a complex landscape.

Monitor and the Competition and Markets Authority (CMA) have been working together to set out their competition approval process for transactions. There are four key steps in the Monitor approval process.

Figure 4. Monitor competition approval process



Monitor has stated that it will provide trusts with guidance on potential competition concerns and the strength of the benefits case. However, ultimately it is the responsibility of the trusts to decide whether to proceed with a notification to the CMA. At the point at which the trusts begin to discuss the merger with the CMA, Monitor has stated that it will cease providing advice on the competitive aspects of the transaction.

The CMA has its own approval process and has the statutory powers to approve or block a transaction. It has set out specific guidance for the NHS, based upon its standard merger review process, but will provide additional support to merging NHS organisations before formal notification is made.

Whilst the CMA is empowered to take the merger decision, it has stated that it will have regard to input from Monitor in relation to the benefits case. However, it remains untested as to how this input will be provided or accepted and the extent to which this will be a smooth process.

The Monitor and CMA approval process is set up to review traditional M&A transactions, where one party acquires another (for example, a large acute provider acquiring a smaller district general hospital). However, the Dalton review is expected to lead to many other types of organisational change such as buddying relationships, management contracts, joint ventures and collaborating along service lines with other providers.

In the past secondary care providers engaging in network arrangements and collaborations, such as, for example, those seen in pathology, stroke and cardiac have typically chosen not to notify the CMA. In fact there are only a couple of such notifications available from the competition authorities. To date, the CMA has steered clear of calling in these collaborations perhaps due to limited resources, a lack of clear policy or the collaboration being sufficiently small to stay below the radar. Similarly, recent health economy reconfigurations (for example Monitor, the TDA and NHS England's review of 11 challenged health economies) have not yet been scrutinised by the competition authorities.

However, it is clear that the CMA is gearing up to become more active in the health sector and that entities engaging in organisational change (even through CCG led health economy reconfiguration) will need to both be aware of the regulatory approval process and engage with Monitor/CMA early before committing significant resources to the project.

Until there have been test cases, this is likely to apply to those engaging in networks, management contracts and buddying – in fact any form of contract where it could be argued that there is single control being exercised over multiple entities. Furthermore, the competition perspective will need to be considered throughout the relationship and sufficient information will need to be compiled to allow both Monitor and the CMA to consider its competitive merits.

We note that some previous NHS transactions have come unstuck due to the benefits presented being insufficient to outweigh the perceived competitive harm. A clear example of this is in the failed merger between Poole and Bournemouth hospitals, where the trusts were not able to evidence and articulate the benefits in a way that met the requirements of the competition authorities. In particular, merger parties should consider the 'counterfactual' option and ensure that they put forward benefits that are occurring as a result of the transaction, rather than those that could be delivered through an alternative organisational form.

Clear articulation of the benefits, combined with patient and commissioner support, are essential to successful competition clearance.

A conclusion of any CMA review could be that organisational change is blocked on competition grounds, yet the trusts involved may not have an alternative plan for viability. Unfortunately, it is not the role of the CMA to consider the wider economic impact of the transaction. This could lead trusts with significant operational and financial challenges and no clear route forward.

Key questions

It is evident that that the approaches described will require a fundamental change of mind-set for many Boards, to shift thinking outside of organisational boundaries. This will be challenging at a time when significant financial and operational pressure is forcing many organisations to focus management time inwardly and most organisations will need support to develop and deliver strong proposals.

But the NHS cannot afford to stand still. Even the best providers will struggle to meet the challenges ahead without looking at how their form could better support new clinical models and ways of working. The 'organisational toolkit' described by the Dalton review offers a potential route to support delivery of the ambitions of the Five Year Forward View and the ultimate future clinical and financial sustainability of the NHS, health systems and individual providers.

The Boards of NHS Trusts and FTs alike will want to consider the implications of these emerging policies for their organisations, and many will wish to get "on the front foot" by developing clear plans, with partners in their local health economies, and potentially acting as early adopters to access the transformational support that will be available to "demonstrator sites" for the new models.

Key questions which trusts need to ask of themselves are:

- **How will the recommendations of the Dalton review affect my 2015/16 Strategic Plan?**
- **What is our vision for the role the trust within the local health economy, for example as relates to integrated care provision?**
- **Should we be planning to link with other organisations to secure our clinical and financial viability? If so, what would be our preferred model? Who would we want to partner with and how will we raise this?**
- **Are we in position to be a kitemarked trust? Do we have ambition as a Board to expand, and if so, what is our plan to be accredited?**
- **What can we do to lead change, not to have change done to us?**

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Endnotes

1. NHS Five Year Forward View (2014) <http://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf>
2. Department of Health, Dalton review: options for providers of NHS care (2014) <https://www.gov.uk/government/publications/dalton-review-options-for-providers-of-nhs-care>
3. Health Service Journal News, Dave West, 23 October 2014 <http://www.hsj.co.uk/>
4. Gaynor M, Laudicella M, Propper C (2012), "Can governments do it better? Merger mania and hospital outcomes in the English NHS" <http://www.bristol.ac.uk/cmppo/publications/papers/2012/wp281.pdf>
5. Kings Fund (July 2014), "Future organisational models in the NHS" <http://www.kingsfund.org.uk/publications/future-organisational-models-nhs>
6. The Kings Fund (September 2014), "Credentialing providers to take on additional responsibilities – an analysis of the evidence and stakeholder views" https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/384198/Credentialing_Report.pdf
7. NHS England and Monitor (2014), "Reforming the payment system for NHS services: supporting the Five Year Forward View" https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/381637/ReformingPaymentSystem_NHSEMonitor.pdf
8. Monitor (December 2104), "Making local health economics work better for patients" <https://www.gov.uk/government/publications/making-local-health-economies-work-better-for-patients>
9. Pearson, Jonathan (2011), "Options for healthcare group working" <http://www.gehealthcarefinnamore.com/insight/thought-leadership/10-thought-leadership/240-29-options-for-healthcare-group-working.html>
10. The Dalton review (2014), "Different organisational forms and their ability to achieve efficiency gains" https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/384126/Dalton_Review.pdf
11. Foundation Trust Network (September 2014), "Review of buddying arrangements, with a focus on trusts in special measures and their partnering organisations" https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/385840/Buddying_Review_web_accessible_FTN.pdf
12. The King's Fund and Foundation Trust Network (July 2014), "Future organisational models for the NHS; Perspectives for the Dalton Review" http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/future-organisational-models-for-the-nhs-kingsfund-jul14.pdf
13. King's College London website – <http://www.kcl.ac.uk/ioppn/depts/pm/research/imparts>
14. Dalton review (2014), "Evidence Pack A: Collaborative Forms" https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/385835/2903219_Dalton_Pack_A_interactive-accessible.pdf
15. The King's Fund (March 2014), "Accountable care organisations in the United States and England; Testing, evaluating and learning what works" <http://www.kingsfund.org.uk/publications/accountable-care-organisations-united-states-and-england>
16. Gaynor M, Laudicella M, Propper C (2012), "Can governments do it better? Merger mania and hospital outcomes in the English NHS" and Kings Fund (July 2014), "Future organisational models in the NHS" <http://www.bristol.ac.uk/cmppo/publications/papers/2012/wp281.pdf>

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