Browne Jacobson

TRANSFORMATION UNIT

# Collaborative Care: Creating Value from Scale

November 2024

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# Introduction

I am very pleased to introduce this summary of two extremely interesting Round Table events which were kindly hosted by the NHS Transformation Unit (part of NHS ML CSU) and Browne Jacobson LLP. It is always fascinating to hear from colleagues in different NHS Hospital group models to understand the context in which their groups were originally formed and the progress that they are making to deliver the benefits. We saw some great presentations which stimulated a lively and interesting discussion.

Measurement of all outcomes is never an easy task and hence we often default to some of the more familiar national performance measures. What is harder to assess is the improvement in organisational resilience and culture which will result in better outcomes for patients and better value in the longer run.

There is no one single way to configure the mechanics of an NHS Hospital group and in fact the evidence implies that the best solutions are those tailored to the local circumstances they set out to tackle.

In the case of my own group, we always saw the local place-based relationships of the trusts as more critical to success than the horizontal relationships across group. We therefore designed a model which retained local autonomy to facilitate rapid decision-making. Our group level roles are therefore advisory only and the group mechanics allow members to share best practice including how best to thrive as a Lead Provider.

The Round Tables also debated the advantages and disadvantages of undertaking a transaction in the NHS. Whilst transactions create a more permanent solution, they come with a big bureaucratic burden which can slow down the delivery of benefits. Many group models have as a consequence opted for a more rapid form of collaboration through shared leadership arrangements, but these need to have an appropriate level of grip in order to rapidly deliver benefits.

Often when I reflect on the development of NHS Hospital groups in the NHS, I flip between having a desire for more structure and guidance versus the reality that greater freedom has led to more innovation. What is clear though is that Association of Groups (a national network of NHS Hospital group Providers run through the NHS Transformation Unit) members are absolutely leading the way in creating effective provider delivery models for the future.

**Glen Burley, CEO**
The Foundation Group of NHS Trusts

# Executive Summary

There have been significant changes to the provider landscape in England over the last 20 years. All providers are now working within a Provider Collaborative in some form, and many are also going further through closely collaborating in other ways such as adopting a form of shared leadership.

Our recent round table events enabled us to explore some of the challenges and opportunities associated with group working, with key learnings summarised below and explored in the body of this report.

- Group models need to be supported by a **clear narrative** articulating the value proposition of the group board and wider group model. The groups we spoke to identified how moving to group models had allowed them to overcome historic differences, a sense of tribalism and a lack of trust that had previously prevented the organisations from collaborating successfully to drive change.
- Groups have choices to make about the model they adopt as they **balance responsibility at-scale and at-site**. Whilst these are not mutually exclusive, the more providers extend the concept of group-wide care/services (the horizonal model) the more likely it is to dilute the benefits of site leadership; and the more providers give power to site leaders (vertical model) the less likely it is that a group will achieve the benefits of service coherence and standardisation across multiple sites.
- Emerging groups must exercise judgment about what structures, including assurance committee structures, fit their individual circumstances. There is a benefit in not having a fixed model imposed on groups. But while there is **no single blueprint** for a group model, there is **commonality in the core legal governance structures** within the group. For a multi-trust group this will be centred around joint leadership and a formal joint committee; for a single merged organisation this will be a unitary board. There is a key role for the directors of corporate governance / trust secretaries in providing assurance as to the mechanics of governance within the model.
- A key benefit of the **multi-trust model** is that it gives time to road-test working as a single organisation, allowing groups to undertake important groundwork for how a merged organisation might operate and thus saving time and costs. This may allow such groups to make a more compelling case for merger if they chose to pursue that route in future.
- Developing a clear risk-led governance and escalation framework is key to a group's success, enabling group leaders to adopt an **assurance focused and strategic approach to leadership**.
- A key challenge is transparency and clarity of governance, supported by effective communications, to help regulators such as the Care Quality Commission to understand their model and how it operates. Developing a sound understanding among staff, stakeholders, regulators and non-executive directors is therefore key to success.

# 1 Context

There have been significant changes to the provider landscape in England over the last 20 years. From over 270 NHS trusts/foundation trusts on 31 March 2004, today there are currently only 209 separate legal entities[1]. This has been against a backdrop of a shift from the apex of a competitive market set out in the 2012 reforms to a policy of collaboration. All providers are now working within a Provider Collaborative in some form, and many are also going further through closely collaborating in other ways such as adopting a form of shared leadership.

While the Health and Care Act 2022 fundamentally changed the architecture of the commissioning landscape it left the provider sector relatively untouched. Instead, it gave all NHS organisations greater flexibility to work together and removing barriers that had previously existed, particularly in respect of powers to delegate decision-making. This has accelerated the pace of development of collaboration between providers. However, the 2022 Act and the associated policy from NHS England has not, to date, been prescriptive in how these flexibilities can or should be used.

Many different factors contribute to the drive for trusts to collaborate. Often this is prompted by local challenges – 'burning platforms' such as financial pressures, leadership capacity constraints, workforce and operational issues, and quality concerns. Formalising of the "triple aim" and associated statutory duty on NHS organisations to deliver system financial targets under the 2022 Act may have further encouraged providers to seek new ways of collaborating to reduce costs across their system. But viewing collaborative arrangements solely as a response to challenges and risks can undervalue the opportunities and benefits that can be realised through group working. Ultimately, collaboration can support providers in their quest to provide safe, effective and sustainable services to the populations they serve.

Whilst the direction of travel has been powerful, there is no single roadmap for providers aspiring to work more collaboratively together – no simple 'blueprint' to aim towards or follow. Group operating models vary considerably, from informal collaboration arrangements at one end of the spectrum to a single merged provider approach at the other. A plethora of models exist along this spectrum, each with its own unique features.

In October 2024, in the wake of the Darzi report[2] commissioned by the new Labour government, the NHS Transformation Unit (part of ML CSU) and Browne Jacobson LLP brought together colleagues from across England to take stock of group arrangements that span the collaborative spectrum. We hosted two 'round table' events where senior leaders came together to discuss the approaches to, challenges of, and opportunities presented by group working. We encouraged participants, and particularly those organisations who kindly presented case studies of their group, to consider the question "*If you were to set up your group model again, what would you do differently?*"

[1] https://digital.nhs.uk/services/organisation-data-service
[2] https://assets.publishing.service.gov.uk/media/66f42ae630536cb92748271f/Lord-Darzi-Independent-Investigation-of-the-National-Health-Service-in-England-Updated-25-September.pdf

This short report has been developed to distil and share the key learnings from the round table events. In it we explore a range of delivery models, supported by the detailed case studies that colleagues shared with us at the events.

While no two groups participating in the discussions share an identical blueprint for a group model there was much common ground in the discussions, from which we have drawn out some of the common challenges to collaborative working and considered how these can be addressed. We conclude by exploring how the benefits of collaborative working can be maximised.

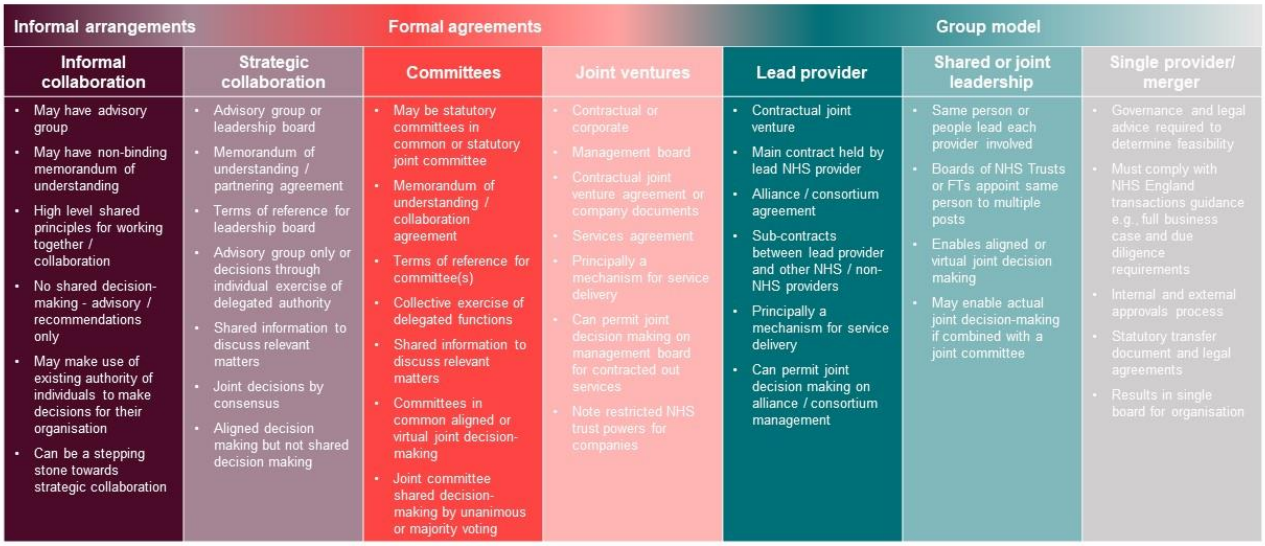
**Acknowledgements**

We are grateful to colleagues from across the country who took the time to contribute so openly to these discussions – epitomising the collaborative ethos which underpins successful group working in the NHS.

# 2 Current delivery models

The extent to which NHS hospitals collaborate varies considerably, from informal collaboration arrangements at one end of the spectrum to a single merged provider approach at the other. A simple overview of this 'spectrum of collaboration' is shown below.

## Spectrum of collaboration




Browne Jacobson

It should be noted that this spectrum is not a series of steps towards an end goal of a single merged organisation. Many groups successfully span multiple statutory organisations, utilising the legislative flexibilities to create a single organisational mind. Conversely, not all single multi-site providers may be considered a group, as it is the federated model of governance rather than size alone that defines a group model.

There is often a perception that there is a wide divergence in group models, particularly when considering groups that are at different stages of their journey. But there is in fact much commonality in the governance structures which those groups explored in this report have implemented or are working towards implementing.

In this section we explore how some of these arrangements play out in practice, drawing on case studies and insight from colleagues at our recent round table events, as well as from our broader experiences of working with NHS providers across England.

It should be noted that while in its guidance *Working together at scale: guidance on provider collaboratives* (August 2021) NHS England defines Provider Collaboratives as partnership arrangements involving at least two trusts, the concept of a "group" as discussed in this report may include multi-trust groups as well as single trusts operating on a group basis.

## 2.1 Developing a group model

The hackneyed saying 'form follows function' was understood by all trusts who attended the round table events. It is important to note that structural change by itself is not the route to improvement. All agreed that there had to be a clear purpose for making the change and that the most common route to create this purpose was to prepare a **problem statement** which describes the challenges and issues which are not capable of being resolved by a single trust.

Some examples of the issues cited include:

- An urgent need to create resilience in fragile services
- Unwarranted variation in patient access or population health indicators
- Inability to reach decisions between trusts who struggle to suppress their organisational interest ahead of the interest of population needs
- An inability to recruit sufficient staff to meet the needs of a 24/7 rota
- Significant system-wide financial deficit
- Inefficient use of capital to invest in equipment and estate
- Different operating systems such as EPR and the effects of this on patient experience and outcomes

Developing a shared view and ambition can help trusts considering collaboration to plan for a solution which addresses the issues identified in their problem statement. Most proceed to develop a **case for change** which describes the improvements that they wish to pursue. This is often followed by a **strategic service development statement** which describes the changes to service models and their possible distribution, which can better meet the needs of the population they serve.

Trusts often develop a shared narrative describing the collective challenges that they are seeking to address and the anticipated benefits they expect to realise, including some (if not all) of the following benefits:

- Sustainable clinical services – resulting from a single service strategy
- Better value from capital investment
- Efficiency improvements from economies at-scale
- Greater workforce resilience and agility, including harmonised rates of pay
- Quicker decision making and reliable implementation of collective decisions
- Rapid improvement to digital maturity
- Scale economies especially to digital/EPR, corporate services including procurement
- Improved operational performance
- Common improvement methodology

The descriptions of these are best expressed in terms of attainable goals, with clear and measurable improvement metrics based on attainable standards and a timetable for delivery.

## 2.2 Operating Model at Scale

The round table events discussed a variety of operating and governance models on the spectrum of collaborative and collective arrangements and the experiences of these across the NHS. Many of the models being pursued include versions of the 'group' archetype.

All versions of a group tend to share common characteristics and are distinguishable from a 'large organisation' (as may result from merger). A group operates through multiple points of delivery (such as hospital sites) with some decision making at a group 'HQ' level. The functions of a group HQ are generally limited to:

- Strategic planning and oversight of strategic direction
- Operating model design, including selection of systems and technologies for standardisation and oversight of a reliable system of implementation
- Strategic investment decisions and major capital planning
- Workforce supply and talent management systems
- Maximum delegation of operational management and delivery to subsidiary organisations

Successful group boards do not get involved in operational decision-making and implementation, other than where agreed plans are not being reliably implemented or are off-track. Usually, an assurance framework is designed to restrict elevation of issues, based upon an assessment of risk, from operational units (hospitals) to group HQ where intervention is deemed essential to prevent failure of delivery.

By way of example, we heard from University Hospitals of Liverpool (the group name of Liverpool University Hospitals NHS Foundation Trust and Liverpool Women's Hospital NHS Foundation Trust) about the detailed work they had undertaken in assuring that operational decision-making remained the responsibility of their separate site/hospital leadership teams. A risk assessment process was utilised to score the extent to which an agreed group plan was at risk of not being delivered. Each action is scored based on impact of risk, likelihood of risk occurring and the extent to which the risk is being managed/controlled. Only the highest risks were elevated to the group leadership team for review.

Liverpool also had determined that group board non-executive directors were not required to lead many of its assurance committees. They have allocated leadership of these to nominated Executives. They believe that their streamlined arrangements allow for quicker decision making and reinforces the model and mindset for the leadership teams of each of their hospitals/ site leadership teams to take local responsibility for finding solutions to their own problems. This liberates group HQ Executives to undertake their specific responsibilities (which are not operational).

## 2.3 Informal Collaboration

The early stage of collaboration involves organisations within a geographical area beginning to explore the potential benefits and efficiencies of working together more closely. Early conversations may lead fairly quickly to informal collaborative arrangements – such as joint advisory groups or agreeing high-level shared working principles. These arrangements are often supported by non-binding mechanisms, such as a Memorandum of Understanding (MoU) between organisations. There are many such examples of informal collaboration across the country, which may focus on a specific service or issue or be more wide-ranging.

Informal collaborative arrangements can be long-standing or can be a temporary 'stepping stone' towards more strategic and formal collaboration. These early stages allow neighbouring organisations to assess and test their strategic and cultural alignment, as well as building trust between colleagues and leaders.

As a current example, in Northwest England **Wirral Community Health & Care NHS Foundation Trust** and **Wirral University Teaching Hospital NHS Foundation Trust** are beginning to operate more collaboratively. Their early priorities include clearly defining and agreeing their future direction of travel, and as part of this considering how quickly they should move towards more formal collaboration, including the potential for shared leadership arrangements in the future.

*"We are just starting on this journey. Pace is something we are already talking about – making sure we don't either go too fast, or not fast enough, and defining the most appropriate governance model whilst being mindful of cultural dynamics and the importance of 'hearts and minds'"*

***Alison Hughes, Director of Corporate Affairs and Senior Information Risk Owner – Wirral Community Health & Care NHS Foundation Trust***

## 2.4 Formal collaborative agreements

Some providers are at the stage of adopting a more formal approach to collaboration, making joint decisions through mechanisms such as Joint Committees and other collaborative governance arrangements. Taking a more formal approach to some degree 'locks in' organisations' commitment to joint working – allowing them to move towards a greater degree of alignment – whilst still maintaining organisational sovereignty (and the associated ability to revisit or back out of these arrangements in the future).

In the Northwest of England, the **Lancashire and South Cumbria Provider Collaborative**, comprising five provider trusts, was formed to enable effective collaboration across the whole of the Integrated Care System. Drivers for the creation of the Collaborative include a history of financial challenges and challenged CQC ratings.

Joint governance arrangements have been in place across providers in Lancashire and South Cumbria for several years and have gone through various iterations. A formal Joint Committee – the Provider Collaborative Board – was established in 2023 as a vehicle which now allows providers to make joint decisions (in line with a framework agreed by the five trusts) to benefit patients and communities across Lancashire and South Cumbria.


www.lscprovidercollaborative.nhs.uk

The Provider Collaborative Board enables the five providers in Lancashire and South Cumbria to work collaboratively and cohesively together on their shared priority areas, whilst maintaining the organisational status quo of each of the five participating providers.

*"Whilst we don't have any plans to change our statutory bodies, we will work collaboratively together to further improve our decision-making processes and accelerate our cross system change programmes".*

***Jonathan Wood, Managing Director – Lancashire and South Cumbria Provider Collaborative***

The Lancashire and South Cumbria Provider Collaborative model is not what may be traditionally thought of as a group model as the five providers maintain organisational sovereignty. But the Provider Collaborative demonstrates an alternative way in which group models can bring together the senior leaders of organisations to effectively work together to tackle specific challenges within their system.

## 2.5 Group models – shared leadership

There has been an increase in shared leadership roles across NHS providers in recent years. There are many locally nuanced reasons behind this overall direction of travel, influenced by the challenging financial and operational environment in which providers operate.

In part of the West Midlands, the key drivers behind two Black Country providers' decision to pursue a shared leadership approach in Walsall and Wolverhampton was clinical and financial sustainability. In the context of significant local challenges, the board of **Walsall Healthcare NHS Trust** approached neighbouring provider **The Royal Wolverhampton NHS Trust** to explore collaborative ways to serve their neighbouring populations. The trusts swiftly adopted a more aligned delivery model – including shared leadership roles – to help address their immediate delivery and financial challenges.

For these two trusts, their group model has evolved and changed over time. Currently the trusts share key leadership roles including a Joint Chair and Joint CEO and have progressed from a non-binding Memorandum of Understanding to a Partnership Agreement which clearly outlines how the organisations operate together. The trusts remain separate legal entities but have established a Joint Committee (the 'group board') to enhance strategic oversight and align decision-making.

Whilst still refining and developing their group model, Walsall Healthcare NHS Trust and The Royal Wolverhampton NHS Trust are operating together effectively and have formed solid foundations from which they can further develop.

Taking this evolutionary approach to the development of a group model has had both advantages and disadvantages.

On the one hand, it has enabled the trusts to make rapid progress in priority areas – those where co-operation enables clear patient, staff, operational or financial benefits – whilst taking a longer-term and more considered approach to matters such as organisational culture and local politics.

> *"We now have one strategy across the group, but we have allowed each organisation to keep their own set of organisational values because this was culturally important to our staff."*
>
> ***Simon Evans, Group Chief Strategy Officer - The Royal Wolverhampton NHS Trust and Walsall Healthcare NHS Trust***

On the other hand, embracing local variation in this way meant the group has had to continually evolve its governance model as the integration between the trusts became stronger. In the context of this evolutionary approach, it has made communicating with stakeholders more challenging. Ongoing effort is required to deliver a clear and consistent message to staff, regulators, politicians, and of course the public.

*"There was an advantage to not having a set view from the start, but there was also a disadvantage. We had to be consistent in delivering a message whilst allowing for some variation and development over time. Continuous leadership visibility and communication have been and continue to be key."*

***Keith Wilshere, Group Company Secretary/Board Secretary - The Royal Wolverhampton NHS Trust and Walsall Healthcare NHS Trust***

Shared leadership arrangements are also well established in the Northeast of England. **North Tees and Hartlepool NHS Foundation Trust** and **South Tees Hospitals NHS Foundation Trust** have a track record of joint working going back many years. In 2021 they recruited a Joint Chair and then developed a Joint Partnership Board to guide the collaboration. This has since developed into full Joint Board arrangements with joint appointments for both Non-Executives and Executives. The trusts have agreed a collective group name of **University Hospitals Tees**, despite remaining as separate legal organisations.

The Joint Partnership Board at University Hospitals Tees takes the non-merged group model to its limits, with everything that it is legally possible to delegate, delivered through shared governance and leadership.

*"Our model is as close to a single entity as we can be and seeks to deliver all the benefits of operating at scale without the complex legal arrangements of a merger"*

**Stacey Hunter, CEO – *University Hospitals Tees***

The ambition and degree of collaboration and integration achieved by University Hospitals Tees is impressive. However, there are certain legal limitations which prevent trusts operating as a single entity without going through the route of a full statutory transaction. For example, trusts are legally required to have their own Councils of Governors, Audit Committee, Remuneration and Nominations Committee, and to produce their own Annual Report and financial accounts. Consequently, North Tees and Hartlepool NHS Foundation Trust and South Tees Hospitals NHS Foundation Trust separately retain these governance forums and discharge these duties, in line with their legal obligations.

Notwithstanding these limitations, there are definite advantages to adopting a joint leadership model. Taking this approach, supported by appropriate and fit-for-purpose governance, is by no means a simple task – but it is significantly quicker and potentially easier to achieve than a full merger would be. It is also likely to be less costly and disruptive than a merger route, whilst enabling a more iterative and gradual approach to alignment – focusing on priority areas first and allowing more time and consideration to be given to 'trickier' matters.

Overall, it can be argued that adopting a shared leadership model can allow trusts to realise some of the benefits of collaborative working more rapidly and easily than would be possible if pursuing the statutory transaction route.

## 2.6 Group models – merged entities

Across England, a growing number of hospital groups have taken the final step on the spectrum of collaboration by adopting a single merged provider model.

The decision to become a single statutory organisation is a significant one.

- Merging organisations can be disruptive to staff and services, requires time and money, and absorbs leadership capacity. Dynamics such as transitioning leadership roles (both Executive and Non-Executive Directors) and (where there is a foundation trust involved) the role of the Council of Governors all need to be carefully planned and thought through.
- The best route to becoming a single entity depends on the status of the trusts seeking to merge (whether NHS trusts or foundation trusts). Approval to merge is subject to robust regulatory review by NHS England against key domains as well as detailed internal due diligence activities being undertaken by the trusts to provide assurance to the Boards and Council(s) of Governors. Secretary of State approval is also required. Trusts need to take pragmatic legal advice on both the route to merger, and the decisions and approvals they need to take and seek as they progress on this journey.
- Merger planning and approvals rely on a detailed understanding of current operations and future plans. This includes how a phased programme of integration will progress following the transaction date, how the merged organisation will operate, how clinical risks will be managed and quality upheld, what the financial implications of the merger will be, and – crucially – how the expected benefits (particularly patient benefits) will be delivered and monitored.

It is not surprising, given these factors, that Boards think carefully before deciding if and when to formally merge.

Increasingly, merger decisions are being taken by trusts who already have an extensive collaborative history. This means that those decisions follow on from a period of joint working, arising due to a shared view that a merger would be a logical next step in the collaborative journey helping to reduce unwarranted variation, improve quality of care, and drive the efficiency and sustainability of services. The benefits of such periods of joint working should not be underestimated, with those trusts that do take this final step of merger finding that their track record of delivery through collaboration and the relationships they have built across their organisation stand them in good stead for the regulatory approvals and post-transaction implementation required.

*"Essentially, there is a sense that the delivery of care is fragmented through having multiple separate sovereign providers. Inevitably, this means we have unwarranted variation in care outcomes, misalignment of resource allocation between providers and many services (clinical and corporate) operating below the scale or scope needed for efficiency and sustainability"*

**Ron Agble, Director of Partnerships and Transactions – *Royal Free London NHS Foundation Trust***

Detailed post-merger plans are submitted, and scrutinised, at the time of the merger business case. Of course, in reality, organisational structures are not ossified in these documents. Rather, they continue to adapt and evolve over time. Joint working in the period prior to submission of a business case may therefore assist in developing a greater understanding of how the larger organisation should be structured.

Multi-trust groups that are informally or formally collaborating will review and refine their governance and operating models over time, seeking out potential improvements. In the same way, merged organisations continue to refine their operating model to respond to challenges and to meet local needs. Merged organisations have greater autonomy and authority to do this than multi-trust groups, and to make swift and binding decisions, meaning that in theory they can react more quickly and decisively when change is required.

Below we consider some of the complexities faced by trusts who have merged, informed by the insight shared through the round table events.

**Moving from a horizontal delivery model to a group delivery model**

Barts and the London NHS Trust which operated St Bartholomew's Hospital, The Royal Hospital London and Mile End Hospital merged with Whipps Cross University Hospital NHS Trust and Newham University Hospital NHS Trust in 2012 to form **Barts Health NHS Trust**. The merged trust serves a population of 2.5 million people, with services delivered by over 20,000 staff members.

Initially a more traditional NHS operating model was adopted across the merged organisation. This involved a horizontal structure of clinical academic groups with clinically-led triumvirate leadership teams spanning across the sites. Having adopted this model, quality and financial challenges began very quickly to emerge, and by 2016 some significant issues had arisen as reflected in CQC reports.

*"We recognised that, by operating horizontally, we had lost focus on sites and individual hospitals which concerned staff and quickly led to a financial and quality gap"*

**Andrew Hines, Director of Group Development – *Barts Health NHS Trust***

In response to emergent financial and quality concerns, site focus was increased via the introduction of a group operating and delivery model with enhanced site leadership arrangements overseen by a group board. Operational accountability was at hospital level, but clinical networks were retained horizontally leading on clinical strategy and standards. This has led to improved quality and financial performance. By organising in this way Barts are able to leverage the benefits from their scale while ensuring effective management and oversight of services at a local level.

Barts Health NHS Trust also work closely with two other acute providers within their Provider Collaborative; Barking, Havering and Redbridge University Hospitals NHS Trust (BHRUT) and Homerton Healthcare NHS Foundation Trust.

Local shared leadership arrangements are emerging and evolving. Whilst not formally part of the group archetype, BHRUT and Barts Health NHS Trust shared a chair in common between 2021 and 2024 when the joint chair departed (due to appointment to the new Labour Government).

Many of the original aims of this collaboration were achieved with BHRUT making significant improvements in performance. The boards agreed to reframe collaboration on a three-way basis under the northeast London Acute Provider Collaborative (APC). In support of this the boards and the ICB agreed to reinstate a separate chair and accountable officer for each trust rather than appoint a new chair in common. Homerton Healthcare NHS Foundation Trust, the third acute trust in the APC will also continue with an individual chair.

Local trusts remain committed to closer collaboration and to ensure the continued momentum of collaboration. The new chair of Barts Health will also chair the APC, with a direct mandate to develop the key collaboration workstreams.

### Rebalancing vertical integration

In 2020 **Mid and South Essex NHS Foundation Trust** (MSE) was formed following the merger of three organisations: Mid Essex Hospital Services NHS Trust, Basildon and Thurrock University Hospital NHS Foundation Trust, and Southend University Hospital NHS Foundation Trust. Following the merger, the trust initially pursued a vertical integration approach (a large matrix model). The original model proved suboptimal, with staff reporting a lack of 'belonging' – being unable to advise which 'care croup' they belonged to. Performance became harder to manage in some specialities due to a lack of clarity on accountability. This resulted in a loss of focus on quality across the patient journey.

The trust reacted by changing their approach – "Organising for Success Operating Model" to facilitate a more clinically-led organisation. Whilst strategic leadership remains at a group level, MSE's three hospital site divisions now have clearer local operational and clinical leadership and accountabilities, supported by broader horizontal matrix working and clinical divisions. Greater emphasis has been placed on the development and strengthening of the site-based leadership model, supported by triumvirate leadership teams and corporate leads.

*"Engagement [around structures] has been really key but also really difficult, recognising the importance of putting effort into steering disciplines. We have undertaken focus groups with medics, nurses and all key staff groups. Regular feedback against a changing model is critical."*

**James Currell, Director of Operations - *Mid and South Essex NHS Foundation Trust***

### Establishing a scalable solution

In 2014, **Royal Free London NHS Foundation Trust** (known as Royal Free) acquired Barnet and Chase Farm Hospitals NHS Trust. In 2017 the Royal Free London group was established to create the organisational platform to reduce unwarranted variation across larger population footprints and leverage scale efficiencies in the delivery of clinical and corporate services. North Middlesex University Hospital NHS Trust became the first 'Clinical partner' to the group, enabling clinicians and operational managers from both organisations to work together on redesigning clinical pathways to reduce unwarranted variation in clinical outcomes.

The intention was to create an effective and scalable group model, which could incorporate providers and enable strong partnerships across primary care, community, mental health and social care services.

One of the challenges in introducing a group model (separating group leadership and 'site' or 'hospital' leadership structures), is that it creates a new level of governance within the organisation – as well as new interfaces between the various 'sites' or 'hospitals' within the group. Both of those elements introduce a greater distance between decision-making forums and frontline staff, which can exacerbate decision-making bottlenecks and stretch oversight mechanisms.

*"Centralised decision-making at times, felt as though it was congested and clunky. There was a tendency for too many items (for example business cases) to be escalated to the group Executive meaning longer turnaround times for decisions and frontline staff feeling too far away from decision-making'"*

**Ron Agble, Director of Partnerships and Transactions – *Royal Free London NHS Foundation Trust***

In response, one of the great early successes of the Royal Free model was establishing 'clinical practice groups' to bring together clinicians, managers, and data analysts across the group. Their remit was to work together to design pathways and minimise variation between group sites.

Today the Royal Free model is structured around group portfolios, with three business units each with their own leadership team. A centralised function serves the business units, and clinical practice groups operate across the group. This model is designed to enable future collaboration and potentially further growth of the Royal Free group.

# 3 Common challenges

Whilst the delivery models adopted vary, we have identified some common challenges that providers face which we explored during our recent round table events.

## 3.1 Finding the 'Sweet Spot'– the interplay between responsibility at-scale and at-site

Most trusts spoke about the considerations they have given to the benefits of scale, across multiple hospitals, and the retention of strong site/hospital leadership. Groups have choices to make – and sometimes there has been a need to reassess and reset the original structural design of their group model. The choices that are available are not mutually exclusive: that is, the more you extend the concept of group-wide care/services (the horizonal model) the more likely it is to dilute the benefits of site leadership; and the more you give power to site leaders (vertical model) the less likely it is that a group will achieve the benefits of service coherence and standardisation across multiple sites.

All trusts at the round table events have considered their approach to this. Liverpool University Hospitals NHS Foundation Trust undertook a deliberate approach to identify every service and to assign it to one of three categories for leadership/management purposes:

- Individual site managed and governed
- Single group services provided on multiple sites but managed and governed by one site
- Centralised services governed and managed on one site

This resulted in a visible matrix of service responsibility with some services managed across the group by one hospital on behalf of others and others managed by individual hospitals.

Many groups at the round table events have now moved to strengthen site leadership and to reduce the number of clinical services which are managed as a single service across the group/multiple hospitals. In order to maintain the coherence and minimise variation that could occur for a clinical service (if it was managed separately from the same clinical service in another of the group's hospitals), many groups have developed arrangements which enable clinicians and managers to develop common service standards, pathways and protocols.

Royal Free has one of the most established arrangements which they call *clinical practice groups*, and in Liverpool these are known as *clinical reliability groups*. These arrangements seek to standardise clinical service practices and to implement the adoption of common equipment and technologies or working practices. The arrangement can also be used to have oversight through benchmarking, for example using GIRFT data to identify variation and a need to improve/standardise to a best practice standard.

Most groups are recognising the benefits that can be achieved through scale for corporate and non-clinical functions. In Lancashire and South Cumbria, a shared priority area identified for the Provider Collaborative Board was greater collaboration across corporate services. While not a "group" in the more widely understood sense, it provides an example of an alternative way in which trusts can bring together services under a single leadership.

## 3.2 Achieve clarity in complexity

The case studies that colleagues shared with us at the round table events provided a good flavour of the diversity of current group delivery model approaches, spanning across the above. As well as those we heard from, we know many other groups exist across England, each operating their own unique delivery model.

Group models involving multiple trusts can often appear complex and novel in terms of the governance structures required. Many group models will adopt a joint committee structure which becomes the "group board" and single directing mind of the group. This is the structure adopted for example by The Royal Wolverhampton NHS Trust and Walsall Healthcare NHS Trust, University Hospitals of Liverpool and University Hospitals Tees.

Individual sovereign trusts must retain their statutory boards (which may have identical or differing membership to those of other boards in the same group). All statutory directors (i.e. voting directors) will usually be appointed to the group board. Many of the groups we engaged with noted the challenges this can bring in terms of creating a very large group board that risks becoming unwieldy. These groups are considering the steps that can be taken to rationalise and streamline board size over time.

Beneath the group board will usually be management boards or similar, which are responsible for the day to day running of each service unit or hospital site. The management board often mirrors the structure of a traditional NHS trust board, with a chief officer, medical director and nursing director. For example, Barts Health and MSE adopt this triumvirate model for site leadership.

An effective group model will take a considered approach to incorporating important concepts such as vertical and horizontal integration, shared and distributed leadership models, and assurance and accountability frameworks. Group models must also consider the wider collaborative context locally, including the roles of Place, Provider Collaboratives and clinical networks. Across England these wider collaboration dynamics vary significantly in their form and maturity, adding additional layers of complexity.

This change to strategic decision-making through a group board with day-to-day oversight of operational management of services delegated to management boards, needs to be understood. It is not about creating an additional tier of management, as the group board and its subsidiary management boards have differentiated roles and responsibilities with the operating model describing the relationship between both. In some models there will be overlap between the management board and the group board, for example where a hospital chief officer also sits on the group board. The round table participants commented in particular that regulators such as the CQC needed to improve their understanding of the arrangement in order to provide credible assessment of the 'well led' domain. Transparency and clarity of governance, supported by effective communications, to help regulators such as the CQC to understand their model and how it operates is critical to a group's success.

As understanding of the group model dynamic continues to grow, and as groups become more ubiquitous and longer-established, groups may find themselves more able to influence the evolution of regulatory activities to better fit their collaborative arrangements. Harnessing collective experiences may be an effective mechanism in seeking to influence this evolution.

Undoubtedly, the lack of a 'blueprint' for groups has significant benefits – allowing as it does the evolution of governance and operational arrangements which are highly tailored to local needs. However, on the flip side, it can be challenging to clearly and compellingly articulate group models that are nuanced and inherently complex.

Whilst the strategic leaders of groups have a rich and deep understanding of the components of their own model, it can understandably be difficult for external parties – including regulators – to appreciate, support and be assured of how these complex models work in practice.

As group models are increasingly recognised as distinct from large provider models, regulators such as the Care Quality Commission (CQC) and NHS England may need to adapt their regulatory approach in response. To help their regulators make sound decisions on the most appropriate approach, individual groups may benefit from developing a clear narrative setting out the core components of their model. Whilst it might prove disproportionate to seek to capture the full detail of group arrangements in a format for external distribution – especially given the ongoing evolution of groups over time – having a clear overarching narrative can help groups communicate a proportionate understanding of how they operate. This narrative can be helpful to both internal and external stakeholders.

## 3.3 Nuances of group leadership

Leadership in the NHS is complex and multi-faceted, and group structures can add to this complexity.

Increasingly, we see the NHS adopting more collaborative approaches to leadership – distributed across teams and organisations rather than concentrated in a few individuals and delivered through influence and empowerment rather than hierarchy.

Joint leadership roles shared across NHS bodies are becoming more common. Joint leadership is not in itself indicative of a group model and several of the groups that participated in our discussions had shared leadership beyond their group. For example, The Royal Wolverhampton NHS Trust and Walsall Healthcare NHS Trust share a chair with two other acute trusts within their system that are not part of their group.

As leaders increasingly work in this way across several sites /organisations, an assurance-focused and quasi-regulatory leadership dynamic emerges. Balancing this dynamic with providing supporting, collaborative leadership can be challenging and requires leaders to adapt their behaviours in response.

*"The group exec team need to develop different approaches to assurance compared to the approach they would take as an Exec of one organisation. But staff need to feel that the Exec are supportive and on the same side. There is a real skillset and mature style of working to hold people to account in a supportive way. It's about behaviours as much as governance structures"*

**Penny Emerit, Chief Executive – *Portsmouth Hospitals University NHS Trust, Isle of Wight NHS Trust***

In our discussions several groups noted the benefits in having a clear separation between the roles of those executives on the group board and the roles of site directors. The latter taking on greater responsibility and oversight of the day-to-day running and management of services, to provide space and freedom for the group executives to focus on transformation and reducing variation through assuring services are delivered to an agreed standard. Conversely some groups have adopted a model whereby key site directors also hold an executive role on the group board. In all cases the development of a clear risk-led approach in terms of what matters are escalated to the group board and what is delegated to site management boards is key.

The tension between boards being focused on strategy and on assurance may be seen as a natural consequence of increased organisational size. But there is a mindset shift required to ensure that group boards have the space to undertake this different role rather than attempting to operate a traditional board model over a much-enlarged organisation. Preserving executive bandwidth through a shift away from the day-to-day running of services for some or all group executive directors was acknowledged as a key factor in the success of a group board. But it was also acknowledged that there is a lack of understanding from regulators for this approach as their expectation remains that all executives, particularly the chief executive, will maintain involvement and knowledge of the detailed operations of the organisations.

## 3.4 Harnessing the power of Governors

For foundation trusts, the Council of Governors plays a crucial role in representing the interests of members and the public. This has been reiterated in NHS England's *Addendum to your statutory duties – reference guide for NHS foundation trust governors* (October 2022):

> *"To support collaboration between organisations and the delivery of better, joined-up care, councils of governors are required to form a rounded view of the interests of the 'public at large'. This includes the population of the local system of which the NHS foundation trust is part. No organisation can operate in isolation, and each is dependent on the efforts of others."*

The Council of Governors perform a range of duties and provide a vital link between trusts and the communities they serve. They play a key role in achieving shared leadership across a group through their statutory role in appointing the chair and non-executives of NHS foundation trusts and in approving the appointment of the chief executive. Any emerging group that wishes to put in place shared leadership across NHS foundation trusts need to bring their Council(s) of Governors with them in the process of developing the group structure.

As larger group providers emerge, so the populations they serve increase in size, making this connectivity more challenging.

We heard how directors of corporate governance and trust secretaries have helped Governors to navigate the changes which included the extension of the concept of membership and elected governors to a trust which is not a foundation trust and which became included within a group arrangement.

Governors are key to supporting Boards to find the best means of delivering the improvements they are seeking. Engaging with governors at the early stages of collaboration is key to designing the most suitable collaborative solutions which retain and promote the connectivity with foundation trust members and the public at large.

Liverpool University Hospitals NHS Foundation Trust already had experience of this through its formation by the merger via statutory acquisition of The Royal Liverpool and Broadgreen University Hospitals NHS Trust by Aintree University Hospital NHS Foundation Trust in 2019 which involved the "shadow" Council of Governors operated by The Royal Liverpool and Broadgreen University Hospitals. As the enlarged trust seeks to further collaborate with local specialist trusts across Merseyside, it will be important to prioritise, at an early stage, effective engagement with Councils of Governors from the collaborating organisations if future arrangements, including shared leadership, are to succeed.

All trusts at the round table events recognised the statutory responsibilities of Governors, expressed within each trust's Constitution which states their role in the appointment process of the Chair and to approve the appointment of the Chief Executive.

Our discussions considered the risk of poor or late involvement of Governors within the process and how this may delay the implementation of group arrangements. It is often helpful for Governors to hear and understand the legal position of proposed changes so that they can ensure they can fulfil their responsibilities for assuring that change is in the interests of the wider membership of a foundation trust.

We heard how many foundation trusts have expanded the role of a lead governor (which is not a statutory role but is required by NHS England's Code of governance for NHS provider trusts (updated February 2023)) to provide leadership within the governors. When considering shared leadership arrangements, it can be beneficial to involve the Lead Governor in developing the Case for Change and subsequent proposed changes to the governance arrangements so that they may engage and involve all Governors in the process and to provide their support for the change.

The role of the trust secretary / director of corporate governance was acknowledged as a key point of assurance for both governors and non-executive directors as they have the important job of ensuring that legal and governance requirements are met within the structure of the group.

# 4 Maximising the benefits of group working

One of the key themes we explored with colleagues at our 'round table' events was how providers can maximise the benefits of adopting a group model. Our discussions centred on three themes, which we explore below.

## 4.1 Articulate the value proposition of the group

A recurring theme in our discussions was the need for a clear value proposition for the group. Many of the participants expressed historical challenges between organisations often with a lack of trust that made service change and delivering benefits to their populations difficult. Many organisations in this position have taken an opportunistic approach to shared leadership, which can then accelerate the pace of change.

Groups articulated the value in having a single organisational mind to direct strategy across organisations, resolving historical challenges such as competing for capital or protectionism over services and clinical pathways. While the participating groups encompassed a range of different operational structures tailored to individual circumstances it is increasingly clear that there are two main ways in which to achieve this single organisational mind:

- Having a single unitary board achieved by merger to create a single organisation. This is the model adopted by Royal Free, Barts and Mid and South Essex
- Having a Joint Committee (group board) with shared leadership. This is the model adopted by multi-trust groups such as Liverpool, Royal Wolverhampton and Walsall and University Hospitals Tees.

It should be stressed that this is not a one-size-fits-all and groups retain the freedom to develop their arrangements to respond to local issues.

It was clear from discussions that there is a pressing need to demystify group model arrangements through clear governance and transparency. Having a clear rationale and value proposition allows groups to provide this clarity for stakeholders, regulators and the public and therefore have the best chance of maximising the benefits of their model.

## 4.2 Focus on alignment not assimilation

Both the merged and multi-trust groups who attended our round tables shared encouraging experiences of successfully tackling priority issues. These success stories often involved achieving alignment in a particular area in response to a pressing need. By way of example, colleagues told us about their achievements in streamlining pathways, standardising clinical policies, and adopting joint management and clinical leadership structures to reduce variation and improve quality.

*"We are having more open and honest conversations. A good example of this is to look at waiting list challenges. We have discussed ways to work on the backlog collaboratively"*

**Jonathan Wood, *Lancashire and South Cumbria Provider Collaborative***

It is certainly possible for providers to become distracted by seeking early and rigid harmonisation in ways of working. The lure of swiftly achieving horizontal integration – and the associated simplicity it promises – is understandable. However, seeking a high level of standardisation and centralisation across a group (or even a multi-site single provider) can prove an impossibly large task. Attempting such an approach can risk causing unintended consequences and cultural resistance.

Colleagues told us of the successes they have experienced by taking a considered approach to alignment which was grounded in an appreciation of local successes.

> "We are extremely mindful that when we came together, we looked at alignment. We have two strong base models, and didn't need them to be the same"
>
> **Simon Evans, Group Chief Strategy Officer – *The Royal Wolverhampton NHS Trust and Walsall Healthcare NHS Trust***

By not only permitting, but recognising and encouraging, appropriate variation – and restricting alignment efforts to key areas in response to priority issues, rather than taking a broad-brush approach – groups can make swift progress in tackling pressing needs whilst also taking proper time to consider and respond to cultural dynamics.

## 4.3 Take time to align

Perhaps inevitably, our round table conversations turned to how mergers and group delivery models interrelate – with discussions covering colleagues' experience of navigating the merger process, the potential benefits of achieving a single organisational form, and the learnings both from providers who merge/plan to merge and from groups who are at the other end of the collaborative spectrum.

Some colleagues from trusts who had been through a merger relatively early in their collaborative journeys reflected that the merger process itself did not deliver their final operating model, and that significant work continued post-merger to iterate their group structures. There was a sense that the work to develop the right group model takes time, and could fall either before, after or independently of a merger decision.

Taking a slower route towards increasing collaboration has distinct advantages.

It allows providers to adopt a 'trial and error' approach to establishing their models, with scope to rethink and address changes which are not working as planned.

Taking time to identify delivery models also allows detail to be worked through – for example, many groups we spoke to have decided to introduce behavioural frameworks for leaders and managers which they have developed to support them in delivering their operating models.

It allows time for cultural alignment. A recurrent theme from our round table conversations was the challenges presented by culture and the time that it takes to work these through. Taking time to align ahead of, or instead of, a merger allows for more easy preservation of important cultural matters. For example, most but not all the groups we spoke to have an aligned set of values across the group, but Royal Wolverhampton and Walsall have shown that it is possible to keep

organisational values separate if these are broadly aligned. Symbols, names and logos are also culturally important. In Tees for example, the group has adopted the name “University Hospitals Tees” with a distinct logo and branding, and a similar approach has been adopted in Liverpool.

Enabling staff and patients to feel a sense of belonging and ownership in their local site is vital. The five adult acute and specialist trusts in Liverpool aspire to become a group. As they progress on this journey, particular attention is being paid to a consistent approach to governance and assurance across the group, site autonomy wherever possible and preserving existing brands which are recognised by patients.

“We want to harness the benefits of working at scale, whilst recognising the importance of keeping existing hospital brands that our patients recognise."

**Tim Gold, Chief Transformation Officer – *University Hospitals of Liverpool***

Additionally, taking time to align allows a controlled and planned transition of leadership roles, particularly allowing for Non-Executive Portfolios to be aligned in a way which considers and accommodates existing skillsets and terms of office.

# 5 Conclusion

As we have explored in this report, in the absence of a 'group blueprint' providers are faced with a range of delivery options when considering how best to collaborate. This means leaders need to make informed choices as they design and develop a tailored model which aligns to their needs and strategic aims.

The NHS TU and Browne Jacobson can help. From the apparent complexity is emerging a core model for group working. Our extensive experience of working with providers across England includes developing their target operating models and associated legal and governance structures, authoring strategic documents including business cases and collaboration agreements, and planning for and implementing change including service transfers, transactions, and target operating model implementation. Get in touch with us to find out more.

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We hope that the insight and opinions presented in this report help provider colleagues across the country as you consider how best to proceed on your collaborative journeys.

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