# Accelerator Support Pack 1
# Module 1: Understanding New Care Models and Workforce Implications

# HLP London Workforce – Developing accelerator support packs to support workforce transformation across London

To support both commissioners and providers a **suite of accelerator support packages** have been developed. The modules in **pink** have been developed and are available via **the workforce portal**, the modules in **blue** are being developed:

**Module 1:** Understanding the New Care Models and Workforce Implications

**Module 2:** Developing Your New Care Model – questions for consideration

**Module 3:** Supporting Recruitment and Retention - New and existing workforce roles

- Physician Associates
- Nursing Career Pathways
- Clinical Pharmacists
- Developing skills in non-clinical roles

**Module 4:** Other Barriers To Working Across Organisations and sharing learning

- Develop Working Group on Employer Governance
- Professional Indemnity

# Module 1

## Understanding New Care Models and Workforce Implications

# Purpose

**Introduction**

This support pack is designed to assist with the development of new care models and to ensure the workforce implications of each of the new care models are fully considered. This is in order to support employees to work across organisational boundaries in accordance with the aims of the NHS **Five Year Forward View** and in line with the vision for **New Models of Care vanguard sites**. It is helpful to describe each of the new models of care to understand better how each of the **models can create differ**ent **implications for working across organisational boundaries** and potential steps to reduce some of these issues.

**How has the pack been developed?**

The support pack has been developed through a desktop review of current literature, through reviewing ***The Dalton Review: Examining new options and opportunities for providers of NHS care (December 2014)*** and new models of care information and through engagement with key stakeholders who are developing the new models of care. The summary has also be reviewed and contributed to by Hempsons solicitors, a national health and social care law firm with expertise in new models of care and other integration projects.

**Aims**

The information seeks to provide a **simplified overview of the different models of care**, help with understanding the new models of care and workforce terminology and provide an overview of the benefits, barriers and governance arrangements for each model including in relation to regulation and workforce considerations. In addition, a **series of case studies** have been included (and these will expand in the coming weeks) with examples from within London and beyond.

**Audience**

This support pack is for health and social care **commissioners and providers** and for key stakeholders in potential new models of care, e.g. **Local Authorities, voluntary sector** etc. The information will be useful for **education** to enable future workforce development needs to be fully assessed and to align workforce development strategies with the development of new models of care.

# Collaborative models

A new model of care involving organisational integration does not always have to prevail. There are a number of successful collaborative working methods between health and social care and across primary and secondary care which can improve quality of care and efficiency. These collaborative models can continue to be used alongside, or instead of, the developing new models of care outlined in the rest of this pack.

**What are the opportunities for collaborative models?**

There are a number of collaborative forms that can be adopted, for example:

- Clinical or Strategic Networks
- Buddying
- Informal partnership such as an MDT team collaborating across health and social care or developing locality teams to look at local population needs.

**Buddying:** Buddying encourages shared learning and drives improvements and is a term used to describe the support that is available to Trusts that have been put into 'special measures' or 'turnaround' after serious failures in the quality of care. They are generally 'buddied' with a high-performing partner organisation. Buddying as a concept has been generally well received by organisations in special measures. A recent example of this is Medway NHS Foundation Trust being buddied with Guy's and St Thomas' NHS Foundation Trust.

**Strategic clinical networks:** Strategic networks are often created by professional groups as a way of diffusing knowledge; disseminating learning and best practice; supporting professional development and to drive the implementation of new ways of working. Clinical or learning networks may align policies between institutions but they do not create new integrated delivery structures. Examples of clinical networks include Stroke and Cancer networks.

**Informal Partnerships**

Often these are based around a need to take an MDT approach or where it makes sense for groups of primary healthcare professionals to come together. Often the group will be multi-disciplinary and look at the needs of the local population and how they can improve services together through working across their organisational boundaries and through developing shared plans, shared objectives or shared pathways of care.

# Quick Guide: key considerations for looking at new model of care

## Before reviewing or choosing a new model of care, commissioners and providers should ask the following questions:

**1. Level Of Integration**

What are your objectives?

**Core Objectives to consider in determined a new model of care:**

- Integrating primary care
- Integrating primary and secondary care
- Integrating health and social care
- Redesigning urgent & emergency services

**Other**

- Expanding services across multiple sites
- Integrating back office functions
- Leveraging technology
- Strengthening out of hospital care
- Strategic estates and primary care development

Go to next slide to see a summary of the 10 models of care

**2. Sustainability**

Does the configuration of organisation(s) need to change or reduce within the local health system?
Can you do this alone?

You may still wish to use Buddying/Informal Partnerships OR Formal Contracts

**3. Risks & Accountability**

Are there any known risks or issues with the relevant commissioners or providers?

**4. Commissioning Function**

Will commissioning functions remain in the new model?

**5. Clarity of Purpose**

How is the governance and accountability going to work?

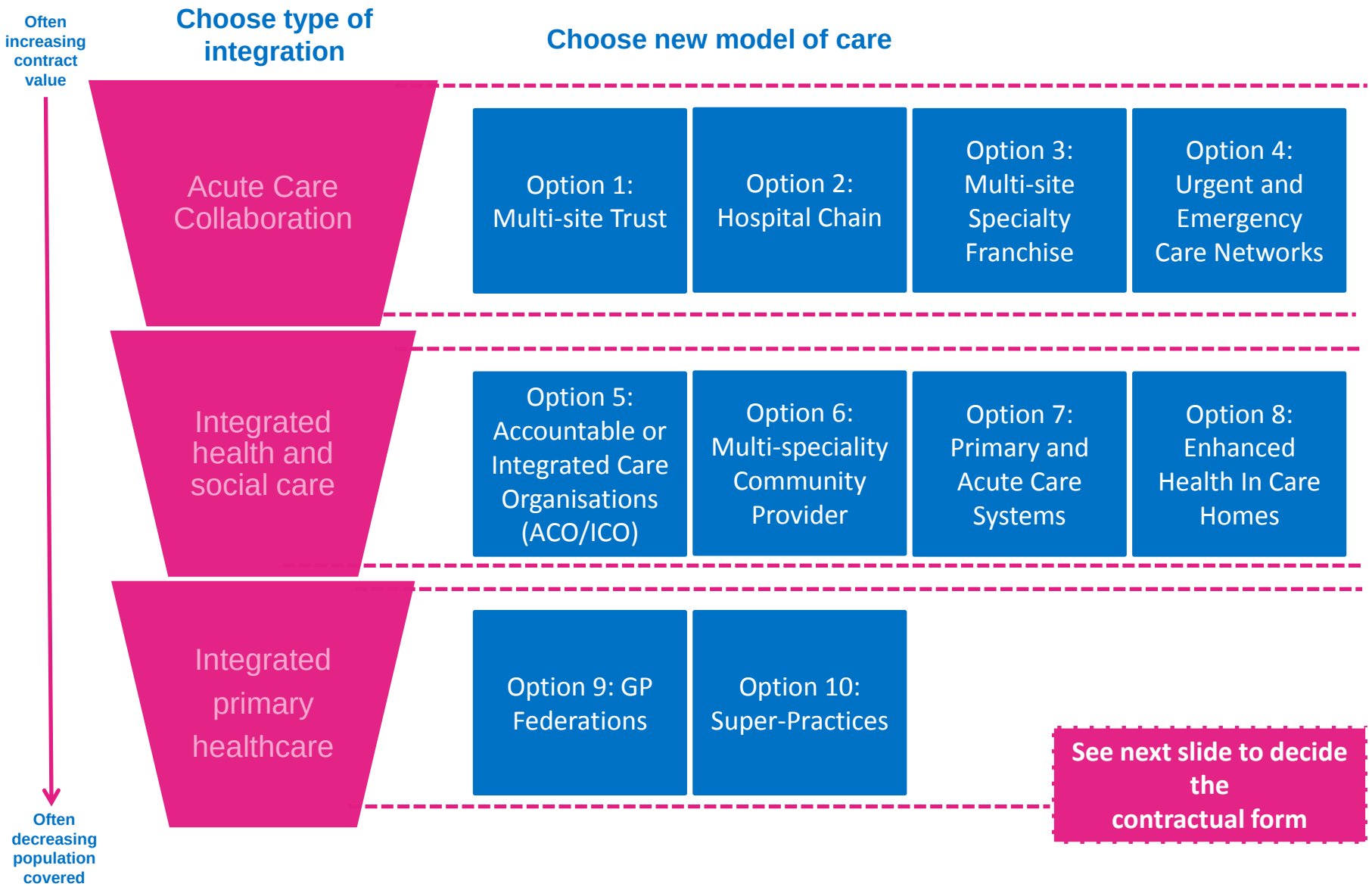
Review the options for new models of care (support pack)

**Agree organisational form and consider implications**

**Workforce implications to consider**

- Complying with statutory duties
- Information Governance
- Competition Law
- Patient Choice
- TUPE
- NHS Pensions

# Summary of the core objectives aligned to new models of care



# Contents

# Option 1: Multi-Site Trust

## Overview

A Multi-Site Trust is where one NHS Trust acquires or merges with another NHS Foundation Trust meaning there are multiple locations available but under separate management.

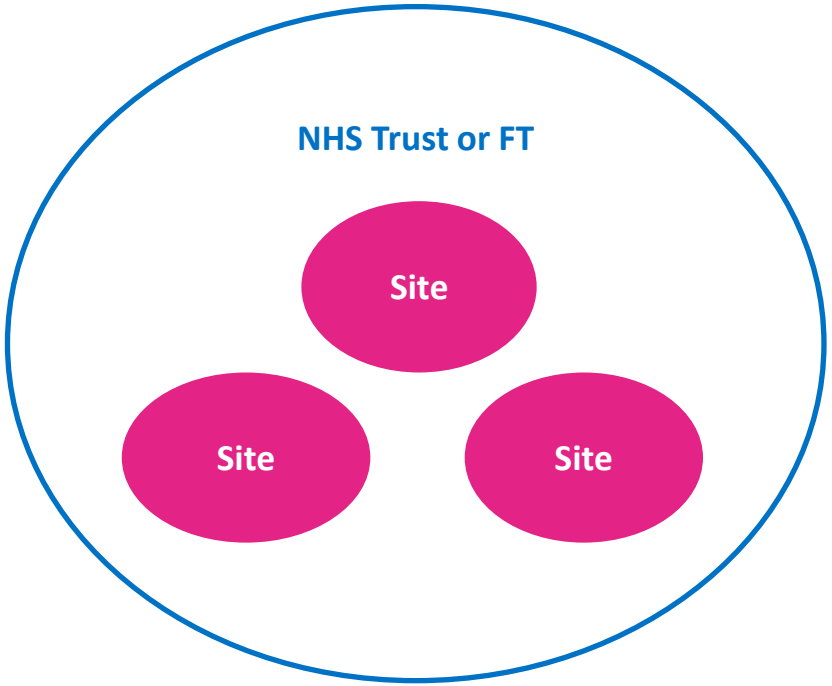
Possible economies of scale through service rationalisation and unified support functions. Ability to move staff between sites to meet changing demand and share expertise. The potential ability to generate greater efficiencies through standardisation across a wider footprint. Codified standard operating model to achieve this.

Through a series of transactions, one provider owns and operates a number of provider facilities . Recent example of this was South Essex Partnership University NHS Foundation Trust acquiring out of area services in Bedfordshire. The model could occur through merger, acquisition or new business developments and could support asset disposal of redundant estate.

There are considered to be 6 key success factors:

- clinician support
- staff and key stakeholder engagement and support
- public acceptance
- adequate resources
- consistency in approach
- clear and considered integration and workforce plan

## Model for Multi-Site Trust




**Examples:**

Royal Free London NHS Foundation Trust's acquisition of Barnet and Chase Farm Hospitals NHS Trust

Merger between Bart's and The London NHS Trust, Whipps Cross University Hospitals NHS Trust and Newham University Hospital NHS Trust

# Option 1: Multi-Site Trust

**The regulatory processes for creation of a Multi-Site Trust through merger or acquisition will require the development of a business case, including consideration of these key issues:**

**Finances:** Does the new hospital/provider have the finances to invest in the assimilation of another organisation?

**Leadership:** Is there the leadership capacity and capability to be able to manage the acquisition of one or more new hospitals?

**Strategy:** Is there a clear strategy in relation to what this will add to the local health economy and quality of services provided to the local population of the acquired sites? How will issues arising from geographical separation of the sites be managed?

**Benefits**

- Improved quality and operational efficiency in new sites by standardisation and replication of proven operating frameworks
- Procedures and policies developed on existing sites shared with new locations can lead to quality improvement
- New sites benefit from strategic leadership, higher standards and support structures offered by the Foundation Group to non-foundation Trusts
- May realise economies of scope through greater focus on operational management and combining back office functions or asset disposal
- May be possible for Foundation Groups to operate in situations that would be unsustainable for some standalone providers
- Allows services to be located at specialist locations

# Option 1: Multi-site Trust

**Governance**

- The formal governance arrangements for single and multi-site Trusts are the same
- Both are led by a Trust Board (and supported by governors and members where the Trust is Foundation Trust)
- For multi-site Trusts there may be different configurations of management teams. One approach is to have dedicated managers responsible for the day to day operational management of the separate sites. Clinical Directors can be designated responsibility for clinical standards at specified sites
- Information relating to different sites can be shared given that all are under the governance and management of one organisation

**Regulation**

- From 1 April 2016 NHS Improvement will be responsible for regulation of both NHS Trusts and Foundation Trusts
- CQC registration will be required for all sites being operated by the multi-site Trust
- Change of ownership may fall within competition law's merger control regime
- Ensure indemnity cover is appropriate

**Barriers**

- Consumes significant management energy
- May require support funding
- The distinction between a merger and acquisition is often blurred for the local population and some stakeholders
- Analysis of previous mergers suggests they have been largely unsuccessful
- Managers being more remote from all sites may create issues
- Different service offerings across the sites need to confirm if they complement or conflict
- Monitor will need assurance regarding leadership capacity and capability
- Ensuring that the organisational culture changes with the change of leadership and name

**Workforce Considerations**

- New leadership structure and strategy
- Due diligence of wider workforce to assess liabilities and create organisational development plan, including issues such as: single divisional structures; staffing levels; skill-mix/flexibility; and benefit of new / extended roles
- Potential redundancies/restructuring exercises with associated consultation processes
- Application of TUPE and the associated information/consultation processes. Note: contract and pensions issues unlikely to arise where all parties involved are NHS employing bodies.
- Develop integration plan covering the organisation's vision, operation, policies and culture in which a cross-section of staff from all organisations should be involved.
- Cross site working/mobility clause issues including excess mileage/travel costs
- Develop measures to support employee retention and development and to enhance recruitment to the organisation
- Identify the education, training needs and regulatory requirements of the current and future workforce, which may include new allied health professional roles

# Option 2: Hospital chain

**Overview**

A chain is distinct from a Multi-Site Trust as it involves a number of organisations operating under the common control of a 'group' entity which sets governance, standards, protocols and procedures, often with centralised procurement and back office functions. Each organisation in the chain is managed by executives with delegated decision-making from the group entity. A high-performing organisation will take the lead in developing the chain.

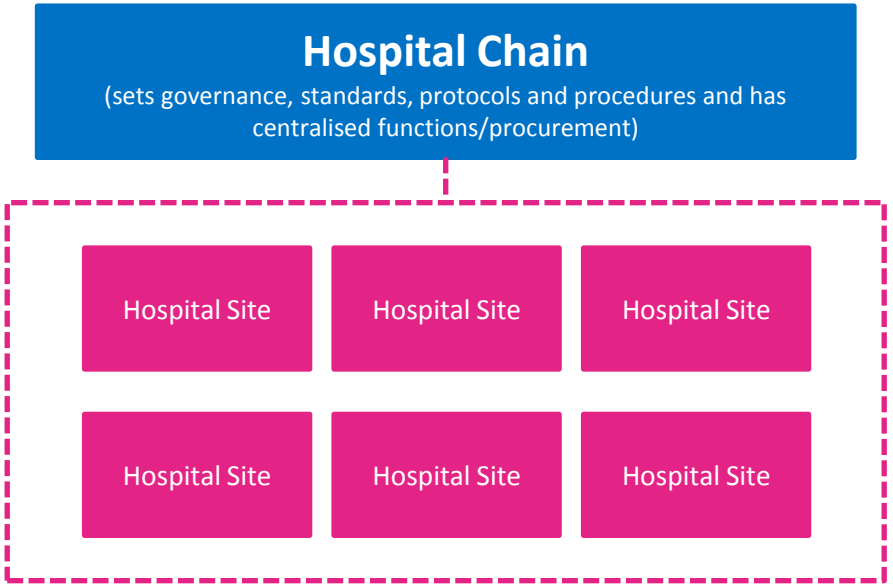
This model has proved to be very successful abroad. It is envisaged this may end the era of 'go-it-alone hospitals'.

Hospital chains enable local access to expert specialist provision, the ability to realise economies of scale across organisations, the development of and association with a specialist brand and access to income from other organisations in the chain. They may deliver acute, community and mental health services.

The core aim is often to improve quality through the standardisation of clinical practices, protocols and procedures.

Chains will be novel in this country, so the governance arrangements will need careful thought. They may be achieved through mergers, acquisitions or contractual arrangements.

## Model for Hospital Chain




**Examples:**

**To follow as develop case study**

# Option 2: Hospital chain

**The regulatory processes for creation of a hospital chain will depend on the organisational form and legal models adopted, but in all cases a business case will be required to address key issues:**

**Finances:** Does the lead organisation have the finances to invest in development of the chain?

**Leadership:** Is there the leadership capacity and capability to develop the chain?

**Strategy:** Which organisations will participate in the chain? Is there a clear strategy in relation to what the chain will add to the local health economy and quality of services provided to the local population of the hospitals in the chain? Will the chain be geographically contiguous or non-contiguous? How will the chain be regulated?

## Benefits

- Lead organisation and other organisations in the chain remain as independent organisations but benefit from being in the chain
- Local access to expert specialist provision
- Ability to realise economies of scale across organisations supporting long term sustainability
- Development of and association with a specialist brand (for example that of the lead organisation)
- Access to income from other organisations in the chain
- Improvements in quality through the standardisation of clinical practices, protocols and procedures

# Option 2: Hospital chain

**Governance**

- Hospital chain is a multi-tiered form that uses a standardised governance system and is led by a 'group' entity which controls governance, standards, protocols and procedures
- A high-performing organisation will take the lead in developing the chain
- Organisations may remain independent while operating in the chain
- The governance arrangements will depend on the organisational form and legal model used to develop the chain, which may involve merger, acquisition or contractual arrangements or a combination of these
- The 'group' entity which controls the chain will set the standards and enforce them, and the satellite organisations, or the spokes, will operate as delivery centres against the agreed standards
- Clear lines of clinical accountability need to be established
- Any sharing of personal data within the chain will need to be on a lawful basis and in accordance with agreed protocols

**Regulation**

- From 1 April 2016 NHS Improvement will be responsible for regulation of both NHS Trusts and Foundation Trusts
- CQC registration will be required for all organisations providing regulated services as part of the chain
- Complexity of regulation of each individual organisation in the chain when under the control of a common 'group' entity
- If whole-system regulation develops, consideration will need to be given to pros and cons of regulation of chain itself rather than individual organisations in the chain
- Change of ownership may fall within competition law's merger control regime
- Ensure indemnity cover is appropriate

**Barriers**

- Success is dependent on the lead organisation's ability to replicate operational practices/ standards
- Decentralised management structure may be less robust
- Transition from a single organisation/site model to a satellite/spoke model can be complex.
- Potential brand and reputation damage if associated with bad practices of other organisations in the chain.
- Challenges with clinical governance and accountability.
- A high performing lead organisation may be sensitive to a distressed balance sheet or performance metrics of a potential partner in the hospital chain.
- May be complex to set up, especially given different legal and governance structures of Foundation Trusts and NHS Trusts (for example FTs are highly restricted in their inability to delegate decision-making beyond the board of directors and NHS Trusts are restricted in their ability to set up corporate entities)

**Workforce Considerations (Note: will be dependent on the organisational form/legal model used)**

- Establish Management Team members/structure
- Where organisations in the chain maintain independence TUPE is unlikely to apply but workforce requirements could change/develop giving rise to the need to change terms and conditions of employment/working arrangements with individual and collective (TU) implications
- Where the chain involves the close collaboration or integration of each organisation's services/staff etc. TUPE could apply giving rise to information and consultation obligations but harmonisation and pensions issues would be unlikely where all parties in the chain are NHS bodies.
- Secondment – identify need for and terms of any secondment arrangements
- Co-working –develop a clear strategy for collaboration/integration and a workforce plan and identify benefit of standardising key policies and procedures
- Cross site working/mobility issues including excess mileage/travel costs.

# Option 3: Multi-Site Speciality Franchise

**Overview**

Under this option, one provider organisation (the 'franchisor') delivers a service or specialty from premises owned by another provider organisation (which in effect 'outsources' service provision to the franchisor). Otherwise known as a 'service-level chain' or the '@' model.

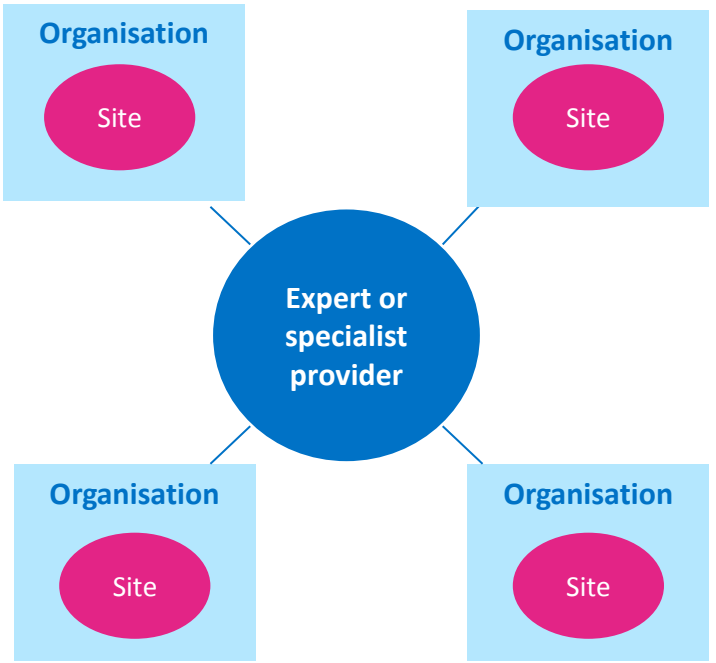
So far the model has proved to be best-suited to relatively self-contained specialties such as ophthalmology and cancer care but does have the scope to be extended to other specialties in due course.

This option may be necessary when an organisation recognises that it is unable to provide services to the required level itself and that it requires access to different expertise, new technology or additional workforce.

For the organisation providing the services, it is a chance to promote and develop their brand and extend the scope of their services, offering potential economies of scale.

This model can be set up in a number of different ways, all of which involve contractual arrangements being put in place between the organisations.

## Multi-Site Speciality Franchise model




**Examples:**

Moorfields Eye Hospital

Alder Hey Children's NHS Foundation Trust

Neuro Network

# Option 3: Multi-Site Speciality Franchise

**The creation of a Multi-Site Specialty Franchise may require the development of a business case, including consideration of these key issues:**

**Finances:** Does the arrangement work financially for both organisations?

**Leadership:** Does the organisation providing the services have the leadership capacity and capability to be able to manage the services at the partner organisation?

**Strategy:** Is there a clear strategy in relation to what this will add to the local health economy and quality of services provided to the local population of the organisation receiving the services? How will issues arising from geographical separation of the sites be managed?

## Benefits

- Organisation 'outsourcing' services receives access to different/ specialist expertise, new technology or additional workforce
- Allows it to focus on core set of services while ensuring the local population still receives access to the wider set of services
- For organisation providing the different/ specialist expertise, new technology or additional workforce it allows them to promote their brand and expand the scope of service delivering, offering economies of scale
- May improve quality through the standardisation of clinical practices, protocols and procedures
- Both organisations remain independent

# Option 3: Multi-Site Speciality Franchise

**Governance**

- The partner organisations will remain independent
- Governance arrangements will depend on the contractual model used to put in place the franchise model
- Key issue will be accountability: whether the organisation providing services is accountable directly to commissioners or, as a sub-contractor, to the organisation receiving services
- The organisation receiving services will remain accountable for the support services it provides at its site for the other organisation to be able to provide its services
- Clear lines of clinical accountability need to be established
- Any sharing of personal data within the chain will need to be on a lawful basis and in accordance with agreed protocols

**Regulation**

- From 1 April 2016 NHS Improvement will be responsible for regulation of both NHS Trusts and Foundation Trusts
- Both partner organisations will continue to be regulated as currently
- CQC registration will be required for all regulated services; may require changes to existing CQC registrations
- Change of ownership may fall within competition law's merger control regime
- Ensure indemnity cover is appropriate

**Barriers**

- Success is dependent on the lead organisation's ability to replicate operational practices/ standards at the organisation receiving its services
- Decentralised management structure may be less robust
- Transition from a single organisation/site model to a franchise model can be complex
- Potential brand and reputation damage for both the organisation providing services and the organisation receiving services
- Challenges with clinical governance and accountability

**Workforce Considerations**

- Create organisational development and co-ordination plan including: staffing levels; skill-mix/flexibility; and benefit of new / extended roles with the aim of aim delivering a capable and co-ordinated workforce.
- Co-ordinated/collaborative working requires staff to have an understanding of other areas/sectors creating potential education/training needs
- Co-working – identify benefit of standardising key clinical/operational policies and procedures
- Where there is close collaboration or integration of organisation services/staff etc. TUPE could apply giving rise to information and consultation obligations but harmonisation and pensions issues would be unlikely where all parties involved are NHS bodies.

# Option 4: Urgent and Emergency Care Networks

**Overview**

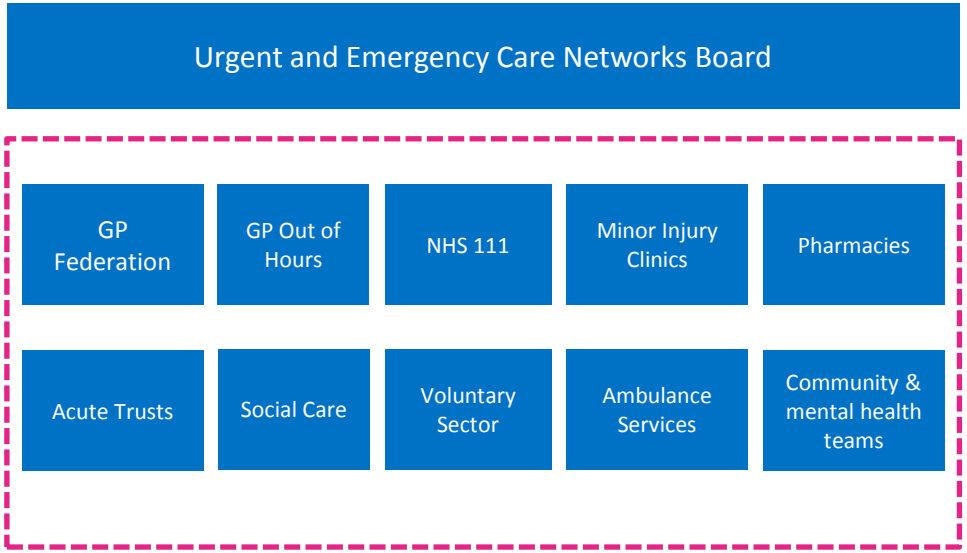
Urgent and Emergency Networks are charged with changing the way in which organisations work together by improving coordination of urgent and emergency care services to reduce pressure on A&E departments.

This includes urgent care delivered not just in hospitals but also in GPs in and out of hours, minor injuries clinics, pharmacists, community teams, ambulance services, NHS 111, social care and others.

The ambitions will be to ensure that care is joined up, decreases fragmentation and that pressures currently being faced by A&E departments are reduced by providing a regional footprint and by encouraging better collaborative working.

These models will focus heavily on using innovative workforce models to ensure people receive the right care in timely ways much closer to home. Within the scope of the models they will focus on improved access to primary care, 7 day working, better support for patients with mental health, promoting self care and developing new workforce roles.

## Model for Urgent and Emergency Care Networks




**Examples:**

Barking, Dagenham, Havering and Redbridge system Resilience Group

North East Urgent Care Network

# Option 4: Urgent and Emergency Care Networks

**The creation of an Urgent and Emergency Network may require the development of a business case, including consideration of these key issues:**

**Finances:** Have you identified possible new payment models in line with the models suggested by NHS England and Monitor? How will you trial and test the new payment models?

**Leadership:** Do you have the leadership capacity and capability to encourage all providers and commissioners to support the network by collaborating towards delivering the shared vision?

**Strategy:** Has the SRG worked in partnership with commissioners to develop the strategy and align with the commissioning intentions process? Is there a clear sense of how this will benefit the network population? Has a plan been developed to extend seven day access to all relevant services? Does the strategy specify how frail patients and those with additional needs due to disability will be managed in all settings? Has the specification for system changes including the desired outcomes been identified and agreed? Are the activity forecasts agreed reflecting the system changes and capacity plans?

**Benefits**

- Focus on 3 key areas – providing an evidence base for high impact interventions, develop sustainable plans for extended access and emergency/urgent care services and complete surge management planning
- Facilitates a way to respond to winter pressures and respond to trends and surges in activity
- Supports management and review of national performance targets
- Enables a forum/network to discuss and resolve local workforce capacity issues
- Improve discharge planning and discharge pathways
- Support the management of mental health patients in crisis
- Promote 7 day working and self care, supporting the prevention agenda by directing patients to services away from urgent care

# Option 4: Urgent and Emergency Care Networks

**Governance**

- The partner organisations will remain independent
- Governance arrangements will depend on the model used to put in place the network
- Key issue will be accountability: clear lines of clinical accountability need to be established
- An Urgent and Emergency Care Network Board may be set up to oversee the network (for example, the Board may be chaired by a senior commissioner)
- The network will need to include all relevant stakeholders commissioning or providing the services and, if a Board is set up, a mechanism will need to be agreed for them to be represented on the Board
- System Resilience Groups (SRGs) may undertake the operational leadership of the local services, ensuring the effective delivery of urgent care in their area, in coordination with an overall urgent and emergency care strategy agreed through the regional Urgent and Emergency Care Network
- Any sharing of personal data within the network will need to be on a lawful basis and in accordance with agreed protocols

**Regulation**

- From 1 April 2016 NHS Improvement will be responsible for regulation of both NHS Trusts and Foundation Trusts
- All partner organisations will continue to be regulated as currently
- CQC registration will be required for providers of regulated activities; changes to registration may be required if the nature of services being provided by organisations changes
- Change of ownership may fall within competition law's merger control regime
- Ensure indemnity cover is appropriate

**Barriers**

- Traditional organisational boundaries and sovereignty cannot be maintained - leaders and management are required to change mind sets and collaborate at every level to the overarching Network strategy
- Deeply embedded sectoral barriers and dysfunctional incentives will need to be removed
- Aligning regional outcomes to various local outcomes across organisations and geographical areas
- Can be challenging given the number of possible partners involved
- Single or compatible data systems can be challenging across organisations, high quality data across organisations is essential particularly for benchmarking across all organisations and for new payment structures
- Size of the Network may affect its ability to make system changes across its locality
- Pricing and risk stratification is essential as well as the ability of commissioners and lead providers to monitor contracts and ensure accountability
- To really transform services significant levels of staff engagement are required to develop new pathways of care and new workforce models

**Workforce Considerations (Note: will be dependent on the organisational form/legal model used)**

- Staffing models should aim to deliver a capable, co-ordinated, sustainable and resilient workforce
- Workforce should be configured, where possible, to work independently so that demand in one area does not impact upon function in another and to support a seven day service
- Effective and innovative leadership with a primary focus on effective collaborative relationships across acute and primary care services to provide a co-ordinated approach to system needs
- New culture of accountability that is likely to require staff training and education
- Where organisations maintain independence TUPE is unlikely to apply but workforce requirements could change/develop giving rise to the need to change terms and conditions of employment/working arrangements with individual and collective (TU) implications
- Where there is close collaboration or integration of organisation services/staff etc. TUPE could apply giving rise to information and consultation obligations but harmonisation and pensions issues would be unlikely where all parties involved are NHS bodies

# Option 5: Accountable Care Organisation or Integrated Care Organisation (ACO/ICO)

**Overview**

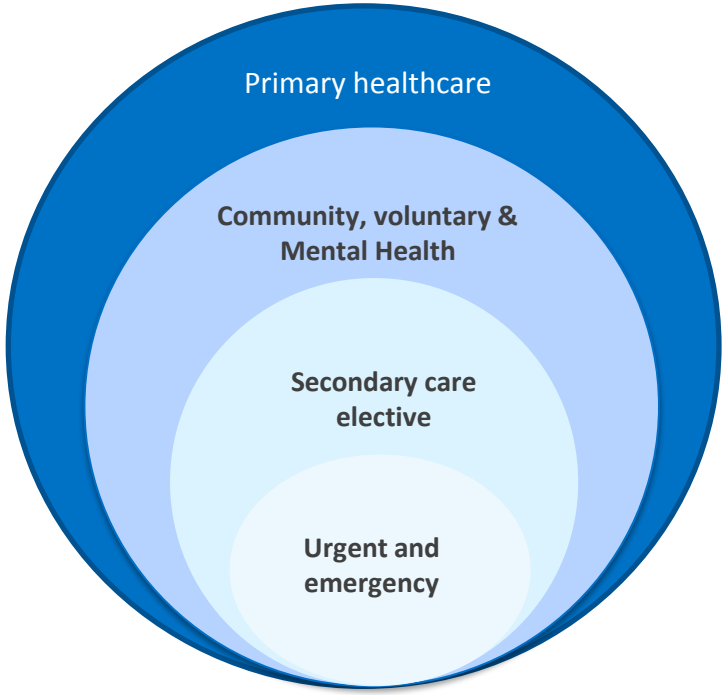
There is wide consensus that across the NHS quality of care needs to be improved and cost controlled. This will require management of local systems – networks of care - not just organisations and out of hospital care will need to become a much larger part of the NHS than it currently is.

There is no fixed definition of an Accountable Care Organisation (ACO) or an Integrated Care Organisation. (ICO). ACOs are usually taken to mean groups of providers that take collective responsibility for the quality and cost of population health, with primary care at the heart of the ACO. They may be supported by shared enablers such as data, IT, estate and workforce. In practice, ICOs may share many of the same features.

Accountable refers to both clinical and financial. They are characterised by a payment and care delivery model that seeks to tie each provider's reimbursement to quality metrics and reductions in the overall total cost of care for an assigned population group. In the NHS, payment models to facilitate ACOs are in development stage.

Integration at this level is likely to require significant upfront investment, which may only generate savings or other benefits over the longer term. It may be complex to set up and is not a quick route to cost savings. It is likely to require significant investment in both the workforce development and IT integration as the ACO / ICO model underlines the importance of sharing data.

**Model for Accountable Care Organisation**




**Examples:**

Salford Together

Greenwich Co-ordinated Care

Cambridge Accountable Care Organisation

Virginia Mason Accountable Care Organisation

Alzira Accountable Care Organisations

# Option 5: Accountable Care Organisation or Integrated Care Organisation (ACO/ICO)

**The creation of an ACO or ICO may require the development of a business case, including consideration of these key issues:**

**Finances:** Are alternative payment and contracting mechanisms being explored with commissioners? Are you able to agree a pricing structure that is acceptable to all partners? It is important to ensure savings made by one part of the system do not negatively affect another. This can be mitigated through contract pricing design. Requires significant upfront investment in IT Integration and workforce development.

**Leadership:** Is there sufficient expertise to manage contracts between partner organisations operating in the ACO/ICO? Will local GPs be integrated as individual practices or as federations? Do you have the infrastructure in place to deliver more services out of hospital including primary and community facilities? What is the plan for the commissioning approach? Will social services be included?

**Strategy:** Have you identified a clear strategy for population based health approaches and identified sufficient data on the relevant population? Have you a clear sense of what value a population health approach would have to support health economy sustainability? Will your ACO/ICO be formed through contracts, new delivery vehicles or mergers? Are all local providers engaged and signed up to the proposal?

## Benefits

- For commissioners an ACO / ICO may allow transfer of risk to providers, subject to commissioners retaining responsibility for their statutory duties
- Allows development of one set of outcomes and objectives, aligned to population needs
- International examples have shown improved patient outcomes and cost savings
- 'Money follows patient' approach allows for defined public expenditure whilst encouraging quality and efficiency
- Incentives ensure that care is provided in the most appropriate setting
- Allows system wide approach to care planning and risk stratification to develop across all providers
- Stronger focus on prevention and maintaining health
- Aligned patient pathways
- Local accountability and shared decision making around a flexible service model

# Option 5: Accountable/Integrated Care Organisation (ACO/ICO)

**Governance**

- Governance arrangements will depend on the model used to put in place the ACO / ICO, but likely to involve multiple partners committing to work together in the medium to long term for delivery of services to a defined population
- Key issue will be accountability: clear lines of clinical accountability need to be established
- An ACO / ICO Board may be set up to oversee the arrangement, including to manage risk and gain share arrangements
- Role of commissioners to be confirmed, from awarding a long term contract to the ACO / ICO to participating in the ACO / ICO Board
- Any sharing of personal data within the ACO / ICO will need to be on a lawful basis and in accordance with agreed protocols

**Regulation**

- From 1 April 2016 NHS Improvement will be responsible for regulation of both NHS Trusts and Foundation Trusts
- CQC registration will be required for all organisations providing regulated services as part of the ACO / ICO
- Complexity of regulation of each individual organisation as part of the ACO / ICO
- If whole-system regulation develops, consideration will need to be given to pros and cons of regulation of ACO / ICO itself rather than individual organisations in the ACO / ICO
- Change of ownership may fall within competition law's merger control regime
- Ensure indemnity cover is appropriate

**Barriers**

- ACO / ICO is an emerging model in the UK
- Traditional organisational boundaries and sovereignty cannot be maintained, - leaders and management are required to change mind sets and collaborate at every level to the overarching ACO / ICO strategy
- Deeply embedded sectoral barriers and dysfunctional incentives will need to be removed
- Aligning regional outcomes to various local outcomes across organisations and geographical areas
- Can be challenging given the number of possible partners involved and the need to ensure the right balance of partners (e.g. role of the acute providers)
- Single or compatible data systems can be challenging across organisations, high quality data across organisations is essential particularly for benchmarking across all organisations and for new payment structures
- Size of the ACO / ICO may affect its ability to make system changes across its locality
- Pricing and risk stratification is essential as well as the ability of commissioners and lead providers to monitor contracts and ensure accountability
- Integration is not a quick way to save costs and should primarily (initially at least) be a way to improve outcomes and patient experience
- In the short term requires investment which if realised will usually be for longer term benefit

**Workforce Considerations (Note: will be dependent on the organisational form/legal model used)**

- Establish effective and innovative leadership focused on strategic integrated service delivery
- Due diligence of wider workforce to identify whether it can deliver a fully integrated service
- Create organisational development plan including: staffing levels; skill-mix/flexibility; and benefit of new / extended roles with the aim of aim delivering a capable, integrated and sustainable workforce
- Potential redundancies/restructuring exercises with associated consultation processes
- Potential application of TUPE and the associated information/consultation processes. Note: contractual, harmonisation and pensions issues could arise where parties involved are from inside and outside the NHS. Consider eligibility for ICO/ACO to be an employing authority with access to the NHS Pension scheme
- Workforce requirements could give rise to the need to change terms and conditions of employment/working arrangements with individual and collective (TU) implications
- Develop integration plan covering the ICO's/ACO's vision, operation, policies and culture
- Knowledge of other sectors – integration requires staff to have an understanding of other areas/sectors creating potential education/training needs
- Managing different contracts and procedures that may necessitate new HR systems

# Option 6: Multi-specialty Community Providers (MCPs)

**Overview**

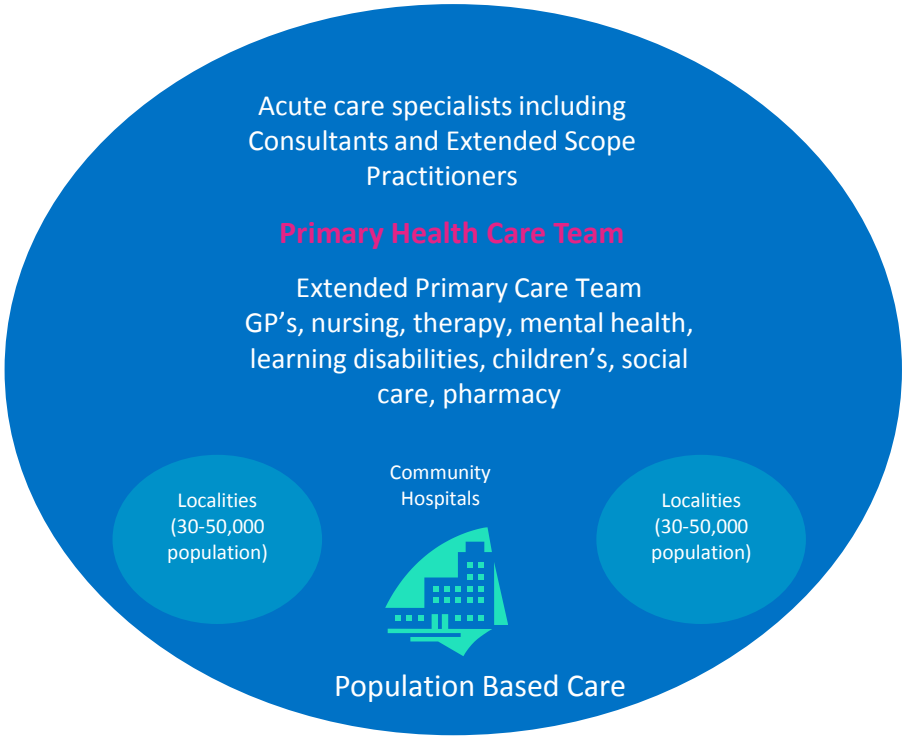
The model envisages the formation of a large group of practices - as federations or super-practices – which would become the focal point for delivery of a far wider range of care needed by their registered patients than is currently the case. This is partly in response to the fact that the traditional GP model is changing with the increase in salaried partners and sessional doctors. It also reflects the need to expand the scope and scale of out of hospital services.

Key features of this model are:

- The aim is to target patients with complex ongoing needs like the frail or elderly or those with chronic conditions and to work much more intensively with those patients
- Larger group practices may for example employ consultant physicians or consultant geriatricians to work alongside community nurses, therapists, social workers and other staff
- These practices would shift the majority of outpatient consultations and ambulatory care out of hospital settings
- They could run local community hospitals which could expand diagnostic services as well as perhaps other services such as dialysis and chemotherapy
- GPs could be credentialed in some cases to admit patients directly into acute hospitals, with out of hours inpatient care being supervised by a new cadre of resident 'hospitalists'
- In time they could take over responsibility for managing budgets for their registered patients, including for health and social care, and create an ACO / ICO

MCP models are complex but are being developed at a number of vanguard sites.

**Model for Multi-specialty Community Providers**




**Examples:**

Tower Hamlets Integrated Partnership

Worcestershire Well Connected Programme

Dudley Multi-specialty Community Provider

# Option 6: Multi-specialty Community Providers (MCP's)

**The creation of a MCP may require the development of a business case, including consideration of these key issues:**

**Finances:** Are alternative payment and contracting mechanisms being explored with commissioners? Are you able to agree a pricing structure that is acceptable to all partners (reflecting differences in primary and non-primary care payment regimes)? Have you anticipated the potential costs and financial challenges? Have you considered the financial risk/gain share and how any surplus may be evenly distributed for service reinvestment?

**Leadership:** Do you have leadership capacity and capability across the partner organisations? Focus needs to be on population health and creating true integration of out of hospital services with clear outcome measures. How will you maintain clinical accountability?

**Strategy:** Have you identified a clear strategy for population based health approaches and identified sufficient data on the relevant population? Have you a clear sense of what value a population health approach would help to support health economy sustainability? Are all provider organisations engaged and signed up to the business case proposal? Does your strategy enable sharing of information?

## Benefits

- Able to offer a range of support in a co-ordinated approach, addressing patient needs locally
- More accessible and more responsive integrated care seven days a week
- Support proactive care in primary and community healthcare setting to reduce acute admissions through better risk stratification and care planning
- Care closer to home through commissioning specific community speciality services such as community Geriatrician and other Consultant services
- Can strengthen prevention and self-care through the role of social prescribing and community pharmacists
- Enable sharing of back office functions and shared investment into new workforce roles, addressing any staff and skills shortages as a system

# Option 6: Multi-specialty Community Providers (MCPs)

**Governance**

- Governance arrangements will depend on the model used to put in place the MCP, but likely to involve multiple partners committing to work together in the medium to long term for delivery of services to a defined population
- Key issue will be accountability: clear lines of clinical accountability need to be established
- An MCP Board may be set up to oversee the arrangement, including to manage risk and gain share arrangements
- The governance arrangements should ensure that all staff groups are represented, with the leadership/board reflecting the diversity of the community based workforce
- Any sharing of personal data within the ACO / ICO will need to be on a lawful basis and in accordance with agreed protocols

**Regulation**

- From 1 April 2016 NHS Improvement will be responsible for regulation of both NHS Trusts and Foundation Trusts
- CQC registration will be required for all organisations providing regulated services as part of the MCP
- Complexity of regulation of each individual organisation as part of the MCP
- If whole-system regulation develops, consideration will need to be given to pros and cons of regulation of MCP itself rather than individual organisations in the MCP
- Change of ownership may fall within competition law's merger control regime
- Ensure indemnity cover is appropriate

**Barriers**

- Complexity of integrating primary and community / mental health / acute contracting, financing and regulatory regimes
- Traditional organisational boundaries and sovereignty cannot be maintained - leaders and management are required to change mind sets and collaborate at every level to the overarching strategy
- Deeply embedded sectoral barriers and dysfunctional incentives will need to be removed
- Aligning regional outcomes to various local outcomes across organisations and geographical areas
- Can be challenging given the number of possible partners involved
- Single or compatible data systems can be challenging across organisations, high quality data across organisations is essential particularly for benchmarking across all organisations and for new payment structures
- Size of MCP may affect its ability to make system changes across its locality
- Contractual terms in the contracts of consultants and other workers could preclude/limit their involvement in the new arrangements

**Workforce Considerations (Note: will be dependent on the organisational form/legal model used)**

- Potential application of TUPE and the associated information/consultation processes. Note: contractual, harmonisation and pensions issues could arise where parties involved are from inside and outside the NHS
- Consider eligibility for MCP to be an employing authority with access to the NHS Pension scheme
- Workforce requirements could give rise to the need to change terms and conditions of employment/working arrangements with individual and collective (TU) implications. For example, on account of the need for new / extended roles for consultant physicians or clinical pharmacists or new working arrangements related to location or hours etc.
- Knowledge of other sectors – integration requires staff to have an understanding of other areas/sectors creating potential education/training needs
- Managing different contracts and procedures that may necessitate new HR systems

# Option 7: Primary and Acute Systems (PACS)

**Overview**

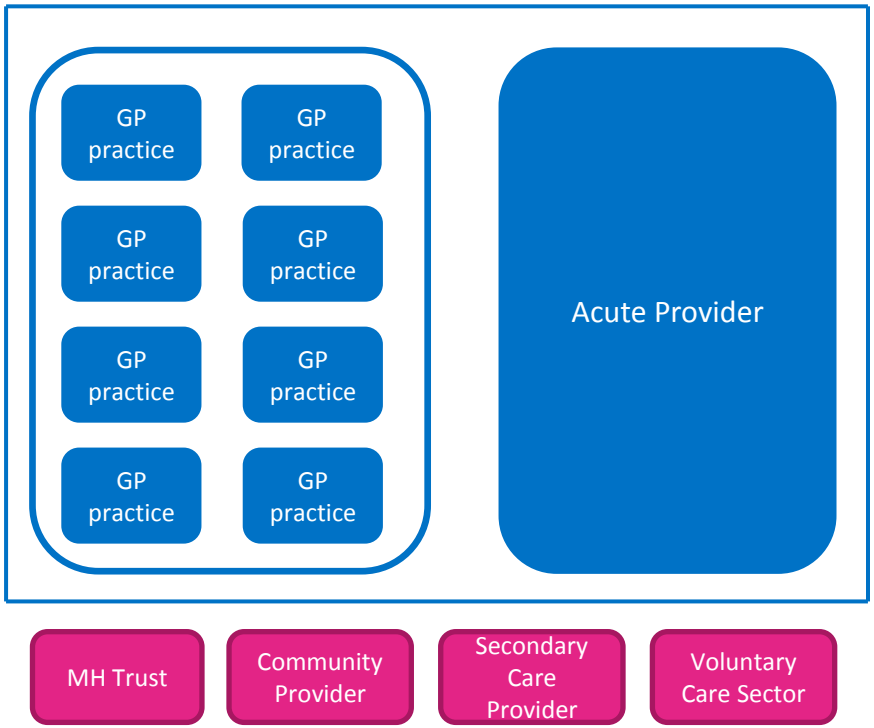
This model is based on 'vertical' integration of primary and acute care services, under which single organisations will be able to provide NHS list-based GP and hospital services, together with mental health and community care services.

Key features of this model are:

- In some circumstances – such as in deprived urban communities where local general practice is under strain and GP recruitment is proving hard – hospitals will be permitted to open their own GP surgeries with registered lists
- Safeguards will be needed to ensure that they do this in ways that reinforce out of hospital care, rather than general practice simply becoming a feeder for hospitals still providing care in the traditional ways
- In other circumstances, the next stage in the development of a mature multispecialty community provider (see Option 6) could be that it evolves into a PACS by taking over the running of its main district general hospital
- At their most radical, PACS would take accountability for the whole health needs of a registered list of patients, under a delegated capitated budget – in effect becoming an ACO (see Option 5).

PACS models are complex but are being developed at a number of vanguard sites.

## Model for Primary and Acute Systems




**Examples:**

**Northumbria Primary Care (NPC) Project**

**North East Hampshire and Farnham Vanguard**

# Option 7: Primary and Acute Systems (PACS)

**The creation of an PACS may require the development of a business case, including consideration of these key issues:**

**Finances:** Have you identified a payment mechanism which aligns the incentives to deliver a PACS? Have you explored the risk and benefit of the funding mechanism? Have you explored the possibility of a new capitated payment mechanism? Have you considered how you will move towards a longer term financial settlement?

**Leadership:** Is there capacity and capability required to lead the development of a PACS?

**Strategy:** Have you identified a clear strategy for population based health approaches and identified sufficient data on the relevant population? Have you a clear sense of what value a population health approach would help to support health economy sustainability? Are all provider organisations engaged and signed up to the business case proposal? Does your strategy enable sharing of information?

**Benefits**

- Integrated primary, hospital and mental health services working as a single integrated network or organisation
- Enables a population based approach to improving health outcomes
- Shared risk for the health of a defined population
- Flexible use of workforce and wider community assets
- In certain circumstances, an opportunity for hospitals to open their own GP surgeries with registered lists
- Possible flexibility for Foundation Trusts to utilise investment powers to kick-start the expansion of primary care
- At their most radical they could take accountability for all health needs for a registered list – in effect becoming an Accountable Care Organisations

# Option 7: Primary and Acute Systems (PACS)

**Governance**

- Governance arrangements will depend on the model used to put in place the PACS – it may be integration within a single organisation or, alternatively, involve multiple partners committing to work together in the medium to long term for delivery of services to a defined population
- Key issue will be accountability: clear lines of clinical accountability need to be established
- A PACS Board may be set up to oversee the arrangement, including to manage risk and gain share arrangements
- The governance arrangements should ensure that all staff groups are represented, with the leadership/board reflecting the diversity of the arrangement
- Any sharing of personal data between different organisations in the PACS will need to be on a lawful basis and in accordance with agreed protocols

**Regulation**

- From 1 April 2016 NHS Improvement will be responsible for regulation of both NHS Trusts and Foundation Trusts
- CQC registration will be required for all organisations providing regulated services as part of the PACS
- Complexity of regulation of each individual organisation as part of the PACS
- If whole-system regulation develops, consideration will need to be given to pros and cons of regulation of PACS itself rather than individual organisations in the PACS
- Change of ownership may fall within competition law's merger control regime
- Ensure indemnity cover is appropriate

**Barriers**

- Complexity of integrating primary and acute contracting, financing and regulatory regimes
- Traditional organisational boundaries and sovereignty cannot be maintained, leaders and management are required to change mind sets and collaborate at every level to the overarching Network strategy
- Deeply embedded sectoral barriers and dysfunctional incentives will need to be removed
- Aligning regional outcomes to various local outcomes across organisations and geographical areas
- Can be challenging given the number of possible partners involved
- Single or compatible data systems can be challenging across organisations, high quality data across organisations is essential particularly for benchmarking across all organisations and for new payment structures
- Size of the PACS may affect its ability to make system changes across its locality
- Contractual terms in the contracts of consultants and other workers could preclude/limit their involvement in the new arrangements

**Workforce Considerations (Note: will be dependent on the organisational form/legal model used)**

- Potential application of TUPE and the associated information/consultation processes. Note: contractual, harmonisation and pensions issues could arise where parties involved are from inside and outside the NHS.
- Consider eligibility for PACS members to be employing authorities with access to the NHS Pension scheme.
- Workforce requirements could give rise to the need to change terms and conditions of employment/working arrangements with individual and collective (TU) implications. For example, on account of the need for new / extended roles for consultant physicians or clinical pharmacists or new working arrangements related to location or hours etc.
- Knowledge of other sectors – integration requires staff to have an understanding of other areas/sectors creating potential education/training needs.
- Managing different contracts and procedures that may necessitate new HR systems.

# Option 8: Enhanced Health in Care Homes

**Overview**

This model aims to give older people a better, joined up health, care and rehabilitation service in care homes.

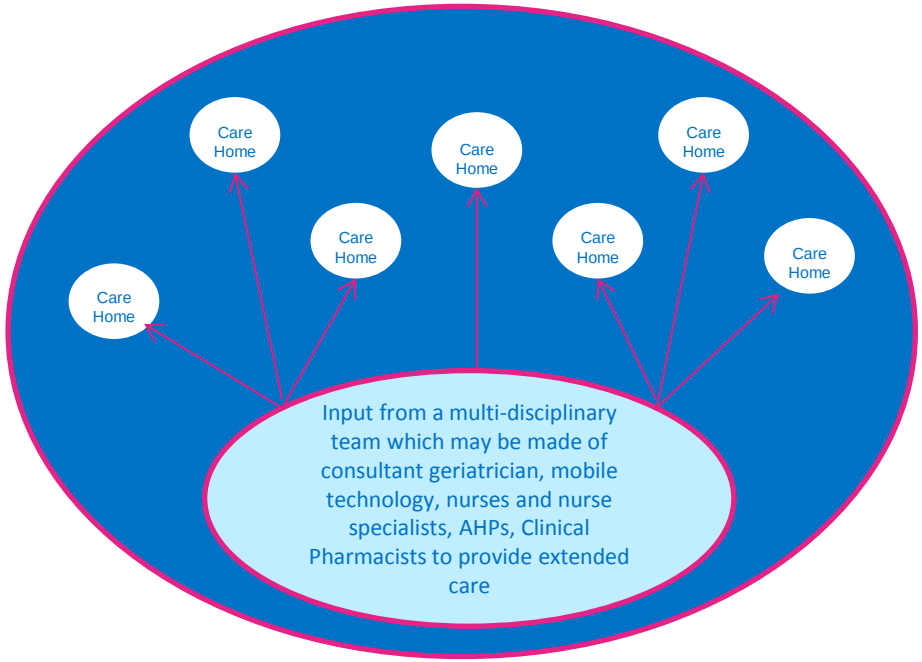
The care home sector often has high referrals and admissions to secondary care which could be avoidable. Patients are less mobile and struggle to attend primary care appointments. The core objective of the Vanguard is to enhance the healthcare of residents in care homes. These frail elderly patients often suffer from complex co-morbidities and are on multiple medications and can often have dementia. These patients have been highlighted in numerous national policies and quality reviews.

The overall objectives are:

- Multi-agency support for people in care homes and to help people stay at home
- Developing new shared models of in-reach support, including medical reviews, medication reviews and rehabilitation services
- Using new technologies and telemedicine for specialist input
- Support for patients to die in their place of choice

A number of Vanguard sites are exploring the potential of this model.

## Model for Enhanced Health In Care Homes Model




**Examples:**

Gateshead Vanguard Care Home Programme

Sutton Hospital Transfer Pathway-Red Bag Initiative

# Option 8: Enhanced Health in Care Homes

**The creation of this model may require the development of a business case, including consideration of these key issues:**

**Finances:** Have you explored new outcome-based contractual and payment models to be commissioned by health and social care commissioners for enhancing health in care homes?

**Leadership:** Is there capacity and capability required to lead the development of enhanced patient pathways?

**Strategy:** Have you identified a clear strategy for outcome based health approaches and identified sufficient data on the relevant population? Have you developed a strategy of how you will work across care home providers to implement the shared vision? Have you developed an engagement strategy including engaging with the public on improving trust, self care and decision making?

## Benefits

- Improved support for complex, frail elderly patients
- Reduction in emergency admissions and non elective bed days
- Reduction in avoidable attendances and admissions
- Better coordinated care through better access and MDT care planning for frail, vulnerable patients
- Improved end of life care
- Can lead to outcome based contracting and improvement in quality

# Option 8: Enhanced Health in Care Homes

**Governance**

- Governance arrangements will depend on the model used to put in place the model – it may simply require changes to existing contractual arrangements or it could involve more complex integration arrangements
- Key issue will be accountability: clear lines of clinical accountability need to be established
- A partnership board may be set up to oversee the arrangement, including to manage risk and gain share arrangements
- The governance arrangements should ensure that all staff groups are represented, with the leadership/board reflecting the diversity of the community-based workforce
- Any sharing of personal data between different organisations in the model will need to be on a lawful basis and in accordance with agreed protocols

**Regulation**

- CQC registration will be required for all care homes providing regulated services as part of the model
- Ensure indemnity cover is appropriate

**Barriers**

- Baseline data may be difficult to identify across all providers given the different systems in place
- Data collection for patients with long term conditions can be problematic
- Single or compatible data systems can be challenging across organisations, high quality data across organisations is essential
- The standardisation of systems will need to include all paper systems in place
- Pricing and risk stratification is essential as well as the ability of commissioners and lead providers to monitor contracts and ensure accountability
- To transform effectively significant levels of staff engagement are required to develop new pathways of care and new workforce models

**Workforce Considerations**

- Establish effective and innovative leadership focused on integrated and enhanced service delivery
- Create organisational development plan including: staffing levels; skill-mix/flexibility; and benefit of new / extended roles with the aim of aim delivering a capable, integrated and sustainable workforce.
- Effective and innovative leadership with a primary focus on effective collaborative relationships to provide a co-ordinated approach to the care home's needs
- New culture of accountability that is likely to require staff training and education

# Option 9: GP Federations

## Overview

GP federations are a form of collaboration based on membership of a separate company, allowing the sharing of resources and costs, but with members retaining own practice autonomy.

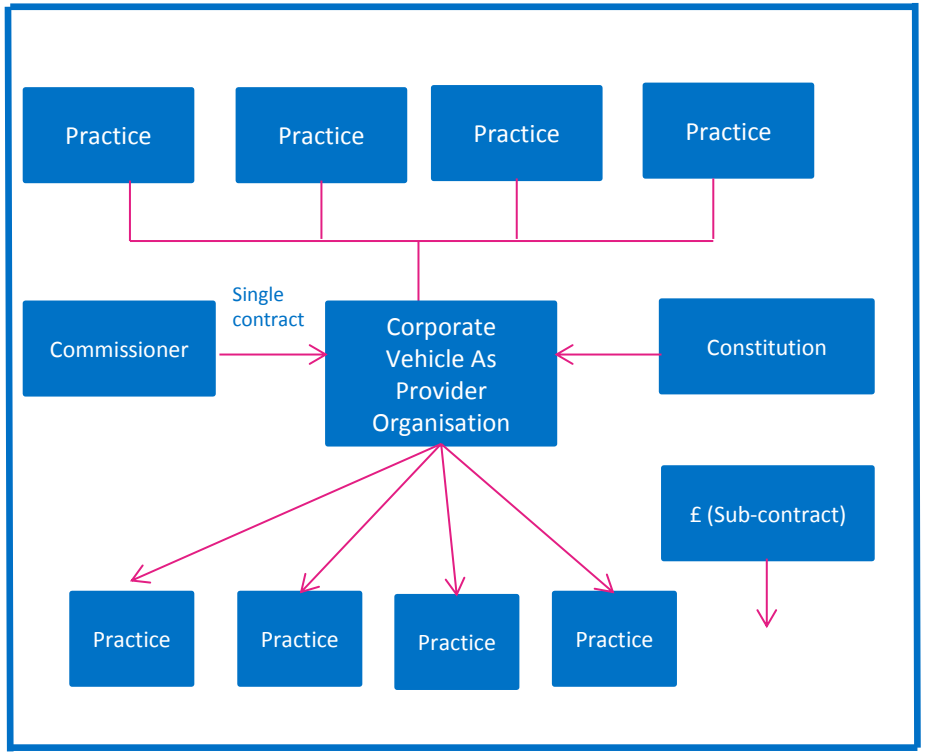
Membership of a GP federation may include some or all GP providers in a locality.

The GP federation will be governed by an elected leadership team. There is an agreed vision, with members aligned to this vision.

Individual practice contracts remain in place with the opportunity for hub arrangements through the GP federation. The GP federation contracts directly with commissioners.

GP federations have a wide range of applications, including the sharing of support services (e.g. HR or procurement), creating standardised care pathways or consolidating specialised clinical services. Engaging with patients and the communities is led by both the federation and the commissioner.

## Provider Model for GP Federations




**Examples:**

Tower Hamlets GP Care Group CIC

Brent GP, Middlesex

# Option 9: GP Federations

**The creation of a GP federation may require the development of a business case, including consideration of these key issues:**

**Finances:** Have you agreed the terms of capital contributions from practices? Have you engaged with commissioners and providers regarding the financial viability of the GP federation?

**Leadership:** Is there capacity and capability required to lead the federation? Are leadership skills required from outside the members? How will you balance the needs to empower the board and to engage with all members on key decisions? What is your plan to utilise support available from the GP federation?

**Strategy:** Has the federation identified and agreed the shared vision? Have you aligned each member to the shared vision and devised a strategy to achieve this vision? How will you engage with patients and stakeholders?

**Benefits**

- Population based and practice based offer
- Members retain autonomy of their own practice
- Relatively easy to implement and set up
- Encourages formal collaboration to improve local services and reduce clinical variation through collaborative working
- Ensures a shared vision across the locality
- Opportunities to improve population health outcomes
- Working together can enable shared back office functions, shared roles and the development of new services
- Increasing income through new business opportunities i.e. AQP, ITT or commissioned contracts
- Support practices to provide high quality services
- Strengthens the size to provide a platform for innovation

# Option 9: GP Federations

**Governance**

- The GP federation will register as a company, this may be as a company limited by shares, CIC or other (the chosen model will depend on a number of factors including access to pensions)
- Members elect the board
- Accountable to the members, regulator and commissioner
- Limited liability for shareholders.
- Risk ring fenced within the GP federation
- Peer review provides governance support for practices to assist with improving quality
- Any sharing of personal data requires registration with the Information Commissioner's Office and understanding of the rules of dealing with personal data

**Regulation**

- CQC registration requirements remain at individual practice level, unless the federation engages clinicians when it will need CQC registration itself
- (Where delivery sub-contracted to practices) service delivery at practice level, accountable to the CQC but performance needs to be managed by GP federation accountable to the CQC and commissioners
- Ensure indemnity cover appropriate

**Barriers**

- Service delivery often remains at practice level and still open to variation
- Capacity of GP federation to manage performance at practice level
- May not be financially viable for commissioners or providers in the long term
- Other organisations may be in a better position to provide better value for money
- Challenge in releasing income tied into acute contracts and impact on Trust viability if large scale changes occur
- Could be seen as primary care being protectionist
- Resourcing at a level to engage with practices and the public

**Workforce Considerations**

- Implement Management Team members/structure.
- Identify what, if any practices resources could be pooled and the anticipated benefits (i.e. shared back office functions such as HR/Payroll/Networked telephony services/new service offerings)
- Identify need for/benefit of new/flexible ways of working at partnership level including with allied health professionals such as clinical pharmacists and any associated regulatory implications.
- Identify opportunities through peer support for standardising training and development of staff at practice level
- Co-working – identify benefit of standardising the practices' key policies and procedures
- Consider eligibility for GP federation to be an employing authority to access the NHS Pension and for sub-contracted income of the practices to be pensionable
- Shared resources and ability to better supports education and training
- Supports recruitment and retention
- Review of training practices and roles

# Option 10: Super-Practices

**Overview**

It is widely recognised that to survive, practices will need to merge to provide competition against core integration and the increase in quality available. It is viewed these changes will allow innovations to emerge such as hiring sessional consultants, becoming diagnostic hubs and becoming pioneers in digital technology.

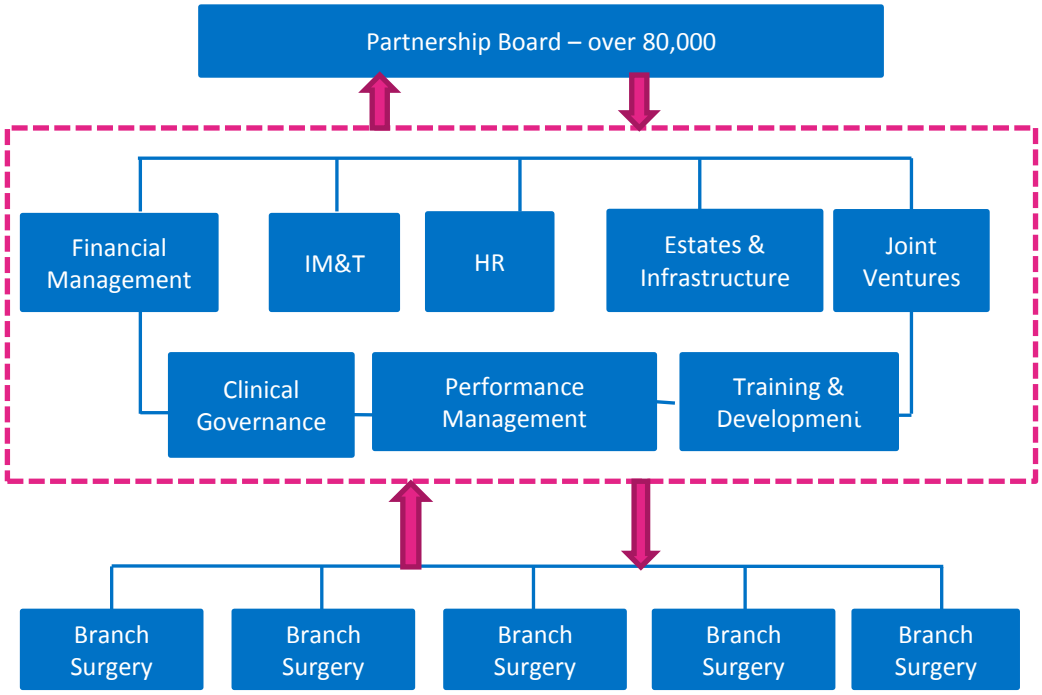
A super-practice is a large-scale single general practice partnership structure that has been created through formal partnership mergers and usually refers to a patient list size above 80,000 although many are much greater in size.

They seek to achieve a greater degree of scale for local general practice, offering a wider range of integrated primary and community health services, and using their scale to offer community-based diagnostic services and consultations with specialists. Its scale also enables a wider range of career development opportunities for GPs and their teams.

Super-practices seek to benefit from diversification of income streams, for example, they often bid to provide community and outpatient services, previously delivered by NHS or Foundation Trusts.

Their organisational and legal form is a single large corporate-style GP partnership, although they often establish one or more parallel companies that can act as the vehicle for bidding for and managing additional services funded by the NHS or private sources, such as dermatology, immigration medicals, or travel vaccinations. They can hold multiple primary care contracts within the group APMS, PMS and GMS.

## Model for Super-Practices




**Examples:**

Hurley Group, London

Whitstable Medical Practice

The Vitality Partnership, Birmingham

# Option 10: Super-Practices

**The creation of an Super-Practice may require the development of a business case, including consideration of these key issues:**

**Finances:** Have you considered the cost of the change including start up costs? Have you reviewed the financial value of all assets and resources?

**Leadership:** Do you have the leadership capacity and capability to lead the single vision? Have you selected members for the leadership board? Do you have fair representation on the leadership board?

**Strategy:** Have you identified a clear strategy for population based health approaches and identified sufficient data on the relevant population? Have you a clear sense of what value a population health approach would help to support health economy sustainability? Are all partners engaged and signed up to the proposal? Does your strategy include the migration of information systems? Have you identified an engagement strategy for patients and the community?

## Benefits

- Offer range of new career options and develop strong MDT working usually employ new roles like clinical Pharmacists, Physicians Associates etc
- Often offer portfolio careers for GPs
- Often enable sharing of records across all practice enabling a single, integrated IT system
- Enables the ability to have seven day working and extended hours
- Improved patient access due to initiatives like telephone triage and shared appointments
- Employ practice management often with high levels of business acumen
- Can address clinical variation and share across practices systems and processes to enable high performance

# Option 10: Super-Practices

**Governance**

- Governance is typically provided by a Partnership Board consisting of an executive group of partners who hold specific management roles within the super-partnership, this group being accountable to a shareholder group of all GPs within the organisation
- However, certain matters can be reserved to the wider Partnership to achieve the correct governance balance
- Accountable to the board, stakeholders, regulators and commissioners
- Single standard contract, managed by a single entity
- Any sharing of personal data requires registration with the Information Commissioner's Office and understanding of the rules of dealing with personal data

**Regulation**

- The Super Practice is a legal entity in its own right, CQC registration will be required
- Each merging practice will cease to operate as a separate Partnership and will continue as a branch surgery of the Super Partnership, so separate registrations will not be required

**Barriers**

- Leadership capacity and capability
- Seven day working implications against existing terms and conditions
- Some may worry that merging a number of other practices to form a large 'super practice' will threaten their own independence and autonomy of practice
- Start up costs may be high
- New organisation will need to build reputation
- Due to the degree of monopoly, strong regulation is required
- Strong regulation is required to ensure quality and safety
- There is a risk and possible shortfall if a branch closes in a certain location
- Due to the large geographical coverage there may be risks if a super partnership fails
- Risk of increases in branch closures
- Possible implications for choice and competition
- GP politics
- Ensuring fit for purpose premises
- Buy in from the CCG, NHS England, RCGP, BMA etc

**Workforce Considerations**

- Implement Management Team members/structure
- Workforce structure/operation and development including: staffing levels; skill-mix; flexibility (ability to offer extended hours and 7 day working); standardised policies/procedures; the benefit of introducing new / extended roles (i.e. Clinical Pharmacists/Allied Health Professionals); and career pathways
- Application of TUPE and the associated information/consultation processes and post-transfer limitations on contractual changes
- Develop workforce integration plan
- Develop training/education development plan to nurture talent
- Gives scope for portfolio careers
- Scope to improve training and education through training practices
- Centralised function to offer better expertise
- More opportunities for staff to specialise

# Legal models for delivering new models of care

**The options:**

- Contractual joint ventures:
  - Lead provider model
  - Lead contractor model
  - Alliance contracting model
- Corporate model – new delivery vehicle
- Merger / acquisition
- Combination or some or all of above

# Pros and cons of less formal legal models

**Pros:**

- Minimises loss of control making it more acceptable to providers
- Lower integration and transaction costs
- Less regulatory processes and approvals required (CMA / NHS Improvement)
- Maintains existing levels of choice and competition
- Can be simple and quick to implement

**Cons:**

- Lack of clarity of accountability and leadership
- Harder to deliver benefits of coordinated care
- Difficulty in sharing risk / reward and aligning incentives
- More likely to unravel

# Pros and cons of more formal legal models

**Pros:**

- Potential to share risk and reward and align incentives across system
- Greater clarity of accountability / leadership and easier to develop own identity
- Improved coordination of care
- Reduced management costs through economies of scale
- More stable – harder to unravel

**Cons:**

- Current payment systems inhibit alignment of incentives
- Regulatory processes and barriers (CMA / NHS Improvement)
- Greater complexity and higher integration / transaction costs
- Possible negative impact on choice

# Conclusion and next steps

- The information within this support pack shows that “Not one size fits all” when it comes to new organisational forms
- It is essential to answer the questions at the beginning of this module in order to determine which kind of integration you are looking to achieve
- It is advisable to seek legal advice at the onset to minimise financial and legal risk
- It is important to engage stakeholders across the whole system including local authority organisations, the voluntary sector and patient participation groups.
- The support pack was developed to provide insight into the workforce issues and the cross organisational barriers.
- The next steps will be to go through a prioritisation exercise to identify which of the issues require a ‘once for London’ solution and determine where no others are working on the solutions or where there is not an identified solution across London or elsewhere.
- A working group will be set up to support and take forward the prioritised workstreams.
- If you would like to get involved, please get in touch using the details on slide 66.

# Get involved…..

Telephone: 0113 807 0161

Email us: England.LondonWorkforce@nhs.net

Post: Healthy London Partnership, 4th floor, Southside, 105 Victoria Street, London, SW1E 6QT

You can also follow us on Twitter at www.twitter.com/#healthyldn

Get involved with the Working Group

Visit the new website and you'll find all of the support packs https://www.myhealth.london.nhs.uk/healthy-london/workforce