

A photograph of three healthcare professionals in a hospital corridor, overlaid with a blue geometric pattern. The woman in the center is holding a tablet and talking to the man on the right. The woman on the left is smiling. They are all wearing light blue scrubs.

No hospital is an island: learning from the Acute Care Collaboration vanguards

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Equality and Health Inequalities Statement

Promoting equality and addressing health inequalities are at the heart of NHS England's values. Throughout the development of the policies and processes cited in this document, we have:

- Given due regard to the need to eliminate discrimination, harassment and victimisation, to advance equality of opportunity, and to foster good relations between people who share a relevant protected characteristic (as cited under the Equality Act 2010) and those who do not share it; and
- Given regard to the need to reduce inequalities between patients in access to, and outcomes from healthcare services and to ensure services are provided in an integrated way where this might reduce health inequalities.

Executive Summary

In 2015, 13 acute care collaboration (ACC) vanguards were chosen to test new ways for acute providers to work together to improve care quality, financial efficiency and workforce sustainability.

This document summarises the lessons learned so far from these vanguards, to support providers and systems considering similar models of collaboration. It outlines what they are doing to improve the quality and sustainability of services, and how their collaborations are managed and governed.

The vanguards are a diverse group, including hospital groups and networks. There are six common areas where they are making improvements by working collaboratively:

- 1) **Standardising clinical practice:**
providing consistently high-quality care by pooling expertise, sharing data and analysing patient care across hospitals
- 2) **Optimising clinical support services:**
standardising, coordinating and consolidating clinical support services, such as imaging and pathology, to improve patient flow and efficiency
- 3) **Optimising corporate support services:**
standardising or consolidating corporate functions and exercising collective purchasing power to save money
- 4) **Making the best use of workforce and developing talent:**
developing creative and flexible workforce approaches to reduce reliance on agency staff, improving continuity of care for patients, and generating new career opportunities to help attract and retain the best staff
- 5) **Building innovative external partnerships:**
attracting investment and co-producing innovative solutions to clinical and management challenges
- 6) **Supporting integrated health systems:**
championing person-centred, integrated approaches through better co-ordinated primary and community health and care, and by investing in prevention

There are three broad types of acute care collaborations: **single-service**, **multi-service** and **hospital group**. These models can use different types of organisational integration, broadly grouped into collaborative, contractual and consolidated models, building on the work of the Dalton Review (2014).

Learning from the collaborations is ongoing. The vanguards demonstrate the fundamental importance of having a shared vision and building relationships between organisations at every level: clinical, managerial and executive. They can testify that for long term, meaningful change, the maxim of 'form follows function' applies.

Evidence of measurable benefits is so far limited. Although the 13 vanguards are diverse in nature, their measures of success cluster in four areas: improving patient access and experience; reducing unwarranted variation; solving workforce challenges; and improving efficiency. However, given the long-term nature of the collaborations it remains too early to make generalisable conclusions on measurable benefits across the whole programme.

There remain plenty of other issues on which we need to learn more, from a national and a local perspective. For instance, do the lessons from single speciality networks, such as Moorfields, readily transfer to other specialties? Is it practical and desirable for hospital groups to spread to non-geographically adjacent areas? How could hospital collaborations make greater use of digital technologies to address workforce and quality challenges?

As the NHS shifts towards working in more integrated local health and care systems, it is crucial to consolidate learning about the most effective ways for hospitals to work together. Local systems have the opportunity to build on these models, test them further and determine how they can support other new care models.

That's why the first wave of eight Accountable Care Systems have been challenged, with support from national bodies, to demonstrate how these new approaches can be implemented at scale to deliver better, more efficient patient care. Every local system needs access to high quality secondary and tertiary care: by working in new collaborative models, hospitals can make this happen.

1. Introduction and the case for collaboration

Background to acute care collaborations

- 1.1 Hospitals in the NHS have always collaborated. These collaborations have tended to not be approached systematically and have often been small in scale. Encouraged in recent years through the Five Year Forward View (2014), the Dalton Review (2014) and the Carter Review (2016), hospitals are looking at ways to work together in formal arrangements and at scale. The establishment of Sustainability and Transformation Partnerships (STPs) across the NHS reinforces the need for new models of provider and commissioner collaboration.
- 1.2 The Five Year Forward View set out a shared vision of the NHS central to which was a move towards an integrated health and social care system through new care models. In September 2015, 13 acute care collaboration (ACC) vanguards were chosen to test different ways in which acute providers can work together to improve care and meet the needs of a changing population. The ACC vanguards are a diverse group that vary by scope of service, number of partners, geographic scale, operating model and organisational form. In terms of service scope, they can be broadly categorised into three types:
- **Hospital groups**
 - **Multi-service networks**
 - **Single-service networks**

Annex A gives an overview of the vanguards.

Figure 1: The ACC vanguards

Type	Key Characteristics	ACC Vanguards
Hospital groups	A number of providers working together under a single group structure. The four vanguard hospital groups have been accredited by NHS Improvement and have formal joint working arrangements.	Foundation Healthcare Group (Guy's and St Thomas' NHS Foundation Trust and Dartford and Gravesham NHS Trust) Northumbria Foundation Group Royal Free London Salford Royal
Multi-service networks	A number of providers working together on a range of clinical and non-clinical service areas.	Developing One NHS in Dorset Working Together Partnership
Single service networks	Networks of trusts and clinicians working on a specific service area. Implementation models range from multi-site care networks to standards-based membership models. The governance and organisational form may also vary and they are unlikely to require a new organisational entity.	Moorfields Eye Hospital NHS Foundation Trust (Moorfields) The Cancer Vanguard Cheshire and Merseyside Women's and Children's Services EMRAD (East Midlands Radiology) consortium MERIT (Mental Health Alliance for Excellence, Resilience, Innovation and Training) West Midlands The Neuro Network National Orthopaedic Alliance (NOA)

- 1.3 The Dalton Review and the Carter Report have both made a strong case for closer hospital collaboration in the NHS. Focusing on the unwarranted variation across clinical standards, financial performance and patient safety, both reviews recommend greater, and more formal, hospital collaboration.
- 1.4 The Dalton Review set out a number of options for how providers of NHS care can work together and the organisational forms which can facilitate this joint working, including: (1) collaborative solutions, where shared services and staff working across organisational boundaries have shared standards and governance arrangements, (2) contractual, and (3) consolidated models to support successful organisations bringing leadership, expertise and processes across organisations.
- 1.5 The Carter Report similarly outlined a number of different ways that organisations could work together to optimise resources through economies of scale and sharing best practice and processes across clinical, non-clinical and support services. The Carter Report suggests that annually there is £5billion of inefficiencies through unwarranted variation across our acute providers.²
- 1.6 Compared to international standards, NHS hospitals tend to be quite large. However, while other countries have developed groups and chains at a rapid rate, NHS trusts have tended to remain working as independent organisations. For example, the AMEOS group operates 68 facilities in Germany, Austria and Switzerland, and typically delivers 20% savings for new sites that it acquires. Intermountain Healthcare, in Utah, United States, operates 22 hospitals and over 150 local clinics.³
- 1.7 The Next Steps on the Five Year Forward View (2017) set out the commitment to “move towards the greatest integrated health system of any western country”. Important to that vision is the integration of acute services and corporate functions across networks of hospitals. Specifically, Accountable Care Systems were challenged to demonstrate how “provider organisations will operate on a horizontally integrated basis, whether virtually or through actual mergers, for example, having ‘one hospital on several sites’ through clinically networked service delivery.” These networked hospital solutions will need to build on and align with national programmes to drive improvements and reduce variation in costs and quality, such as Getting it Right First Time, RightCare and the Model Hospital.
- 1.8 Working within an NHS landscape that has not always lent itself to collaboration, the acute care collaboration vanguards are testing models of hospital collaboration that can be scaled across the NHS. While the vanguards are predominantly working in acute services it is expected that these models of provider collaboration may offer insights for other areas, including mental health and community services. This paper describes the key lessons learnt from the vanguards: what they are doing to improve the quality and sustainability of services, and how they are organising themselves to deliver these changes.

2, 3 Operational productivity and performance in English NHS acute hospitals: Unwarranted variations (The Carter Review), 2016.

Why are hospitals motivated to work together?

- 1.9 Three goals describe the motivations for hospital collaboration: to improve care quality; improve financial efficiency; and improve workforce sustainability.

Figure 2:



Improve care quality

- 1.10 Unwarranted variation in care exists within and between hospitals in the NHS. This is detrimental to the optimal use of NHS resources and the quality and efficiency of care experienced by patients.⁴ Patients should be able to access consistently high quality care, regardless of location. However, reducing variation can be difficult and takes time to achieve. Programmes across the NHS such as Getting it Right First Time (GIRFT), RightCare and the Model Hospital are producing guidance, tools and support to help providers address these variations in care. Multi-provider collaboration enhances the opportunities to address variations in care by sharing data and best practice, and developing standardised pathways.
- 1.11 There are a number of causes of variation in care quality. Whilst some of this variation is acceptable, unwarranted variation represents an opportunity for improvement. For example, the mean length of stay for emergency admission to hospital for fractured neck of femur ranges from 9.9 to 30.6 days, a 3.1-fold variation. Many differences can be attributed to localised processes and insufficient implementation of best practice care. Collaboration allows trusts to work at a scale larger than individual hospitals to access and implement best practice across multiple hospitals.

4 Operational productivity and performance in English NHS acute hospitals: Unwarranted variations (The Carter Review), 2016.

- 1.12 Unwarranted variation may also be due to preferences for treatment options in clinical decision making. Clinical judgement to choose different treatment options for different patients is fundamental to effective care and to facilitate patient choice and control. However, where these decisions result from siloes in clinical knowledge or are due to slow adoption rates for new treatments it can lead to a diminution in quality. For example, the proportion of patients with rectal cancer undergoing pre-operative radiotherapy varies from less than 10% in some trusts to over 80% in others.⁵ By working together hospitals can address these issues by maximising the contribution of clinical audit and improving education and training.
- 1.13 In addition, some unwarranted variation can be due to the supply of people and resources available to hospitals and their clinicians. The provision of care in different hospitals depends upon the availability and skill of healthcare professionals, while treatment options can depend upon the availability of beds and diagnostic equipment. By working together trusts can make best use of the workforce and optimise the use of clinical support services to ensure patients have access to services and receive the optimal treatment and care for their condition.
- 1.14 Collaborative working around acute services can enable hospitals to improve quality through system-wide planning of services. For some specialised services such as stroke and vascular care, patients can have better outcomes when treated by multi-disciplinary teams working exclusively in dedicated facilities. In some instances this supports the case for consolidation of services between sites. For example, when 32 stroke units in London were consolidated into eight hyper-acute sites there was a 7% relative reduction in 30 day mortality and a 7% reduction in length of stay.⁶

Improve financial efficiency

- 1.15 The NHS remains one of the most efficient health care systems in the world. However, rising healthcare costs, demographic pressures and constraints on public finances mean the NHS faces significant financial challenges that will continue over the coming years.
- 1.16 Efficiency improvements need to be found across the NHS. Many opportunities are within the acute sector, for example, by reducing variation in the costs of care between different providers. The cost of an inpatient treatment varies by 20% between the most expensive and the least expensive NHS trust.⁷ This can be improved, for example, in the 12 months after the pilot programme for Getting It Right First Time an estimated £30m to £50m savings in orthopaedic care have been made.
- 1.17 Working as part of a group or network can allow providers to achieve further efficiencies such as consolidating and standardising corporate functions, pooling resources, combining procurement power or partnering on capital investments.

5 Abercrombie, John (2017) General Surgery: GIRFT Programme National Specialty Report.

6 NHS England (2014), The Five Year Forward View.

7 Operational productivity and performance in English NHS acute hospitals: Unwarranted variations (The Carter Review), 2016.

Improve workforce sustainability

- 1.18** Ensuring NHS providers are staffed with the appropriate number and mix of clinical professionals is vital to the provision of quality care and keeping patients safe from avoidable harm. The NHS faces a challenge to make sure there are enough people with the right skills employed in the right settings. The Next Steps on the NHS Five Year Forward View (2017) sets out some plans to meet these challenges, including increasing the number of nurses in training, reducing the reliance on temporary staff and addressing specific staff shortages in areas such as radiology and emergency medicine.
- 1.19** Some locations, hospital types and specialties find it particularly challenging to employ the appropriate number and mix of clinical professionals. The shortage of staff in some specialty areas, such as emergency medicine, radiology and midwifery, presents particular difficulties for the delivery of services. General Medicine and A&E accounted for 64% of locum spend in 2016/17.⁸ By working together trusts can increase their capability to make more flexible use of a workforce across multiple sites.
- 1.20** Provider collaborations facilitate innovation and varied experience which can make them more attractive places to work for people wanting to broaden their development and build portfolio careers. Partnership working can create new resources and opportunities to invest in the workforce and develop leaders.

⁸ Liaison (2017) Taking the Temperature: A review of NHS agency staff spending in 2016/17 - www.liaisonfs.com/ttt.

2. Acute care collaborations: six common improvement strategies

2.1 Whilst the acute care collaboration vanguards are assuming different forms (see Chapter 3), their strategies for improvement are similar. There are six common strategies being implemented to improve care quality and sustainability.

Figure 3: Six common improvement strategies



Standardising gall bladder care at the Royal Free London

Strategy 1: Implementing standardised clinical practice

- 2.2** All vanguards are working together to improve the quality of care and reduce unwarranted variation across their group or network. A collaborative approach allows them to pool clinical expertise, develop analytical resources and use their size to spread best practice. Vanguards are implementing a range of approaches to encourage standardisation. This includes bringing clinicians together to develop, share and implement best practice across multiple sites, creating new data sets, benchmarking performance and using quality improvement methodologies.
- 2.3** At both the **Royal Free London** and **Salford Royal** hospital groups, formal mechanisms have been put in place to bring clinicians together in multi-professional groups to share and implement evidence-based best practice through the creation of 'Clinical Practice Groups'. The clinical experts within these groups are responsible for systematically identifying and addressing unwarranted variation across the group. Together, they define clinical standards, processes, and pathways in their clinical area and support their implementation. Feedback loops and shared data systems enable constant iteration and improvement.
- 2.4** The **Cheshire and Merseyside Women's and Children's Services** vanguard has established clinically-led networks across 10 trusts in four specialty areas: paediatrics; maternity; neonatal; and gynaecology. Clinical protocols and quality dashboards are being implemented across the vanguard to ensure adherence to the standards and provide quality assurance.

The **Royal Free London** is using a 'Clinical Practice Group' approach. It is focusing on standardising practice and offering care in the most appropriate setting so that high volume, less complex cases will be treated at the Barnet and Chase Farm hospital sites, while smaller numbers of more complex cases will be treated at the Royal Free Hospital site.

By having multi-professional teams analysing the variation and reviewing the processes, a number of opportunities have been identified to improve quality and patient experience in the gall bladder pathway. This includes: rapid delivery of testing; eliminating unnecessary repeat imaging and other investigations; improving the timeliness of surgical intervention through using day case surgery where possible; and reducing the likelihood of re-admission. As a result the cost of delivering specified parts of the service is on the way to reducing by £500,000 – which is around 10% of the total cost of that pathway.

The aim is to improve patient experience by giving people access to more timely treatment and reducing the need for follow up appointments.

Case study

Reducing variation in hip fractures in the North East

HIP QIP is a hip fracture quality improvement programme which has been run for a number of years by **Northumbria Healthcare NHS Foundation Trust**. This programme is based upon multidisciplinary teams, supported by detailed measurement of care processes, learning from data and implementing changes quickly. It is informed by patient surveys at admission, discharge and post-discharge. Teams have identified improvements such as prioritising additional nutrition for patients with hip fractures, giving quicker access to surgery and improving pain management. These changes, amongst others, led to trust-wide 30 day mortality reducing from 14.3% to 8% and improved patient experience.

The trust is already sharing this approach with six other organisations. Northumbria's group model offers the prospect of spreading this approach further, alongside other quality improvement initiatives.

- 2.5 The **Cancer Vanguard** has taken the model of clinically-led standardisation further, by bringing experts together from three of the country's leading cancer alliances to co-design pathways in lung, colorectal, oesophago-gastric and prostate cancers. The vanguard is producing best practice timed pathways for each of these specialties. These can be implemented for the 10.8 million people within the vanguard's geography and could also provide a blueprint for implementation across the country, through the emerging Cancer Alliances.
- 2.6 Standardising care across the whole country is also the goal of the **National Orthopaedic Alliance (NOA)**, whose five founding partners are working together to design clinical quality standards, in partnership with the Getting it Right First Time (GIRFT) programme. Membership of the alliance includes the responsibility to implement these standards, but also the support to do so. Over 20 providers are supported as part of the alliance. Members of the alliance have access to an information portal where they can self-assess against the standards, benchmark their performance to identify areas of improvement and access buddying arrangements to support implementation. **Moorfields** vanguard is collaborating with the NOA and GIRFT to replicate this model for ophthalmology nationally as the UK Ophthalmology Alliance (UKOA).
- 2.7 At the **Foundation Healthcare Group** the work of standardising care is jointly led by cardiologists from Dartford and Gravesham NHS Trust and from Guy's and St Thomas' NHS Foundation Trust, working closely with GP colleagues. By mapping patient journeys, they identified significant duplication and delays within pathways. The team developed four standardised pathways including virtual clinics where cardiologists and GPs together undertake case reviews of patients that the GPs are concerned about. Early data shows a reduction in duplication of tests, expedited transfers to tertiary care where required, and improved patient experience.

A regional platform for radiology in the East Midlands

Strategy 2: Optimising clinical support services

- 2.8 Working together between trusts provides opportunities to coordinate clinical support services and combine them where appropriate. It is well recognised that services such as imaging and pathology offer much potential for creative collaborative solutions across hospital sites. The approaches vanguards are taking include standardising processes and protocols, sharing systems and platforms, and consolidating services into a single hub. Such interventions can improve patient experience, smooth patient flow, and save money.
- 2.9 A number of vanguards have implemented, or are implementing, similar shared information systems in radiology to optimise functions. For example, the **Working Together Partnership** has established a managed clinical network for radiology across its seven trusts. The network is currently working towards acquiring an IT platform that will allow images to be shared across the vanguard and support workflow.
- 2.10 The **Mental Health Alliance for Excellence, Resilience, Innovation and Training (MERIT)** vanguard, a collaboration of mental health trusts, is developing a co-ordinated bed management system across its four partners. This will use an electronic bed viewer to enable bed managers from each trust to see bed availability in real time across all four trusts. A shared patient record system is being developed to support this, which enables patient records to be accessed

In the **East Midlands Radiology (EMRAD)** consortium eight trusts have pooled their resources to jointly procure a single system for storing images and patient information. This cloud based system allows radiologists and clinicians across the vanguard to see a patient's record in real time, regardless of their geographical location. This means a radiologist based in Nottingham can provide an opinion on an image for a patient in Lincoln rather than the two days currently required under manual information sharing.

Consolidation of software across these trusts should reduce the time patients wait for diagnosis and increases provision for out of hour's major trauma and stroke services; improving the patient journey and experience. Importantly, it offers enhanced support to clinical colleagues running services in smaller hospitals or outpatient services in the region.

Implementing the system has been a major change project for the trusts. Deploying a large IT system across multiple locations inevitably carries large risks and the project has encountered technical problems, which has led to some performance issues and one trust intending to leave the consortium.

In response, the technical provider has been required by the consortium to resolve the system's problems. When facing these issues, the consortium continues to be based upon principles of partnership working across the region.

Case study

Royal Free London – standard pathology testing

Optimising clinical support services can be done by standardising protocols across the group or network to reduce unwarranted variation between departments and providers. This can save money and improve patient experience by decreasing waiting times.

Royal Free London has studied variation to identify areas for improvement. An analysis of the A&E departments within the group demonstrated that in one department an average of fourteen tests were requested for one presenting condition compared to six in another department. In response the vanguard implemented standardised pathology test requests for patients presenting with common symptoms and built this into the IT systems to encourage ordering of standard test sets. So far savings of £8,000 per month have been reported due to a reduction in unnecessary and duplicative testing.

by participating sites. This should mean patients are more likely to be admitted to a bed within the West Midlands rather than being transferred out of the area, improving patient experience and outcomes.

Shared services across the Working Together Partnership

Strategy 3: Optimising corporate support functions

- 2.11 Vanguards are maximising the potential of collaborating on corporate support services, such as payroll, procurement and IT, by standardising processes, consolidating services, and by leveraging collective purchasing power. For example, the **Northumbria Foundation Group** provides a number of the more usual corporate service functions such as payroll, finance and procurement for a wide range of other trusts. Additionally, Northumbria has developed a wider range of shared service offerings including Fleet Solutions, which provides a fleet of over 20,000 vehicles to over 170 NHS and public sector organisations on a salary sacrifice model. This shared service model has enabled Northumbria and the participating NHS organisations to generate income to reinvest in patient care. Northumbria's group model offers the potential for extending these services further.
- 2.12 Acute collaborations are extending the benefits of cross-provider access to electronic patient records. **The Foundation Healthcare Group** has developed a local care record with King's Health Partners Academic Health Sciences Centre, enabling clinicians in King's College Hospital NHS Foundation Trust, Guy's and St Thomas' NHS Foundation Trust and South London and the Maudsley NHS Foundation Trust to view patient records across the three organisations. The care record is now being rolled out to Dartford and Gravesham NHS Trust as part of the group model, with the expectation that it could be extended across the whole Kent and Medway STP.
- 2.13 The **Working Together Partnership** is implementing a similar system to allow clinicians access to patient test results across the vanguard through their Integrated Clinical Environment (ICE) OpenNet application. This allows a clinician to view the test history of patients across the connected sites, ensuring a more complete diagnostic history is available for clinicians treating patients attending different hospitals. As well as reducing clinical risk by minimising unnecessary patient interventions and repeat tests, it supports improved care through timely access to patient results and improves the overall patient experience.

The **Working Together Partnership** has a strategy for shared services that spans its seven acute trusts as well as local mental health and community trusts. Areas of focus include human resources, payroll, finance and procurement. The trusts are participating to improve efficiency by sharing best practice and maximising economies of scale.

The partnership has achieved savings from the joint purchasing of a range of routine medical and surgical consumables. A joint procurement and common approach to usage has generated £2 million saving for items such as examination and surgical gloves, needles, sutures and dressings. The trusts now have a common tender management solution and contracts database to support this approach and are implementing a regional procurement catalogue. The vanguard is also taking a common approach to legal services and e-rostering and has developed common schemes for absence management and agency staff.

Strategy 4:

Making the best use of the workforce and developing leaders

- 2.14 Working together, providers can be more effective in recruiting, retaining, developing and deploying staff than operating in isolation. Acute collaborations show that staff can be used more flexibly across sites and that new ways of working can be developed. These groups and networks may also become more attractive employers, offering more rewarding and flexible career opportunities including the potential for portfolio careers. Overall this can help reduce reliance on agency staff, reducing variation in care and improving efficiency.
- 2.15 To address the challenge of how small district general hospitals can recruit and retain staff, the **Foundation Healthcare Group** vanguard is testing new consultant workforce models between a tertiary provider (Guy's and St Thomas' NHS Foundation Trust) and a local hospital (Dartford and Gravesham NHS Trust). This can increase the ability for Dartford to recruit staff who otherwise may not have considered joining, and enables consultants from Guy's and St Thomas' to work more closely with Dartford. This has been put into practice in a shared respiratory pathway between the two trusts which includes monthly consultant clinics at the district general hospital.
- 2.16 A number of vanguards have recruited to joint positions across two or more trusts to encourage joint working and provide flexibility in how staff are deployed. For example, **Developing One NHS in Dorset** has established a scheme to share medical staff between the four trusts in the region during periods of significant staff pressures at individual trusts. In addition, a number of joint appointments have been made to support the move towards a single pathology service. Whilst such examples are not new to the NHS, acute care collaboration can ensure they are implemented more systematically and on a larger scale.
- 2.17 Reducing the reliance on agency staff is another driver for new workforce models. **MERIT** is developing a flexible staff bank for clinical and non-clinical staff across its four partners. Reviewing the training needs and skill-mix of staff, including developing a training 'passport', helps staff to move more flexibly between organisations. The vanguard forecasts this will help partners achieve annual reductions in agency staff costs of between £3-4 million. Similarly, **Northumbria Foundation Group** is implementing a collaborative staff bank across the North East and Cumbria region. Initial work has focused on recruiting medical bank staff and this will be extended to include other healthcare professionals.
- 2.18 Working collectively has given a number of vanguards the opportunity to redesign roles within their workforce to meet changing needs. The rising demand for radiology services and the constrained supply of radiologists has encouraged **EMRAD** to develop the capability for NHS radiologists to report across multiple NHS sites and reduce the reliance on independent contractors. This approach is supported by a single technology platform and a change in how payments are made for radiology services. With university partners, **Working Together Partnership** has developed a structured education programme for new roles, such as direct-entry sonographers.

2.19 New models of hospital collaboration also open up leadership development for staff. **Royal Free London**, for example, has helped develop the London Leadership Academy, a pan-London NHS leadership development organisation. The programme is multi-professional and multi-organisational and is designed around collaborative leadership styles. As the group develops, more clinical directors and system leaders will be able to access a range of support and relevant training. **Developing One NHS In Dorset** has adopted the Arbinger Institute methodology to develop system leadership. One-to-one sessions, group sessions and cross-trust development days have brought leaders together and encouraged honest dialogue which has led to a better understanding between them and a fresh appreciation of their shared aims.

Case study

Working Together Partnership multi-site working

The **Working Together Partnership** has been able to reduce its reliance on temporary staff by taking a regional approach to the provision of out-of-hours specialist services. Shared rotas have been developed across the seven trusts in a number of specialties including ophthalmology, ENT (ear, nose and throat) and OMFS (oral and maxillofacial surgery).

In ophthalmology, a regional 'hub-and-spoke' model is being implemented to ensure consultant-led cover is provided for emergency care, with back up cover at other sites if emergency patients cannot be transferred to the regional hubs. Taking this approach reduces the need for locum cover, which has previously been relied upon because of difficulties in recruiting to ophthalmology vacancies at middle and consultant grades. This makes the hub and spoke model a safer and more sustainable service across the region.

Similarly, a shared out-of-hours ENT rota has been developed. This has enabled consultant cover to be provided for three out-of-hours ENT hubs across the region, with a separate specialist paediatric emergency ENT rota based at the Sheffield Children's Hospital. This reduces the need for locum cover and increases the quality and sustainability of ENT services.

OMFS clinicians across the region are exploring ways of further collaborative working to improve the elective and emergency service, including a regional approach to consultant rotas to help mitigate consultant vacancies.

Strategy 5: Creating innovative external partnerships

2.20 The vanguards are using their scale, brand and influence to establish new partnerships with public, private and voluntary sector partners.

2.21 For example, the **Foundation Healthcare Group** has attracted additional charitable funding from its partnership with Roald Dahl's Marvellous Children's Charity. This will provide support to the 300 families in Kent who have a child with epilepsy, by funding a new epilepsy nurse specialist providing specialist care closer to home. This service will reduce the need for children to take time out of school to travel to London. Similarly, the **Cheshire and Merseyside Women's and Children's Services** vanguard partnered with Widnes Vikings rugby league football club, Liverpool John Moores University and a technology consultancy to develop a programme called Game Changer which supports daily physical activity for children.

Case study

The Cancer Vanguard's 'Pharma Challenge'

The **Cancer Vanguard** covers a population of 10.8 million and brings together some of the most pioneering cancer providers in the country. This creates opportunities for innovative projects in partnership with industry. One example is the 'Pharma Challenge', organised between the vanguard and the pharmaceutical industry. The aim of the challenge is to improve the availability and delivery of chemotherapy and systemic medicines for cancer. Pharmaceutical companies were invited to submit proposals to improve the availability and delivery of cancer drugs which were judged by a panel of chief pharmacists, nurses, clinicians, health science and other professionals. Five pharmaceutical companies were selected:

- Amgen – a model for out-of-hospital administration of denosumab
- Celgene – an interactive medicines optimisation and compliance dashboard and evaluation framework
- QuintilesIMS – analysing medicine usage data and quantifying the costs associated with unwarranted variation
- Sandoz – improving the uptake of biosimilars through an education and engagement programme
- Bristol Myers-Squibb (BMS) - developing a system that captures, identifies and treats the presentation of an immune-related adverse event quickly and effectively.

In addition to the direct benefits for patients and the NHS, it is estimated that £200,000 additional support has been made available to the vanguard as a result.

Cancer Vanguard 'Gateway-C' Primary Care Education Tool

The Greater Manchester part of the **Cancer Vanguard** has developed 'Gateway-C', an innovative online primary care education tool to support cancer referrals.⁹ This resource supports GPs in identifying patients with potential cancer symptoms, and ensuring efficient referral for diagnostic screening that is timely and the patient is prepared for. Given the prevalence of stage 3 and 4 diagnosis of lung and colorectal cancers in Greater Manchester. The tool focused on these pathways for the pilot.

A further pilot is now taking place at the UCLH Cancer Collaborative, and the platform is being further developed and rolled out across primary care across Greater Manchester and Eastern Cheshire. This is an example of how networked models can help spread innovation in both primary and acute care.

Strategy 6: Supporting integrated health systems

- 2.22** Acute care collaborations work in partnership with the rest of the health and care system. They need to contribute to strong local health and care systems, through STPs and the emerging ACSs. A number of the vanguards are modelling this approach, including working with partners in community and primary care to support individuals to live healthy lives through prevention, better self-care and the integration of primary, community and local acute services.
- 2.23** For example, **The Neuro Network** has redesigned primary care pathways for headaches, seizures and back pain improving quality and reducing unnecessary referrals. It has done this through all acute trusts in Cheshire and Merseyside operating as a network under leadership from specialist provider The Walton Centre. The headache pathway includes a set of guidelines for GPs across Cheshire and Merseyside to aid decision making on whether patients with headaches and simple migraine should be referred to specialist services or be managed within primary care. Since the initial pilot, the pathway has led to an increase in minor headache and migraine cases being managed in primary care and the Walton Centre reports a 6% reduction of referrals. This pathway is now being rolled out across the whole of Cheshire and Merseyside.
- 2.24** The **Cheshire and Merseyside Women's and Children's Services** vanguard is working with primary care partners to drive change across both primary and secondary care. For example, they have implemented a training programme to develop an advanced paediatric nurse workforce to delivery paediatric services across primary and secondary care. It is anticipated that this will improve population health and ensure that children are treated close to home where appropriate.
- 2.25** In other areas, vanguard-led work on acute services is being incorporated into the local health system. For example, **Developing One NHS in Dorset** is central to the vision of the Dorset Acute Care System to build 'One Acute Network'.

⁹ <https://www.gatewayc.org.uk/>.

3. Implementing an acute care collaboration

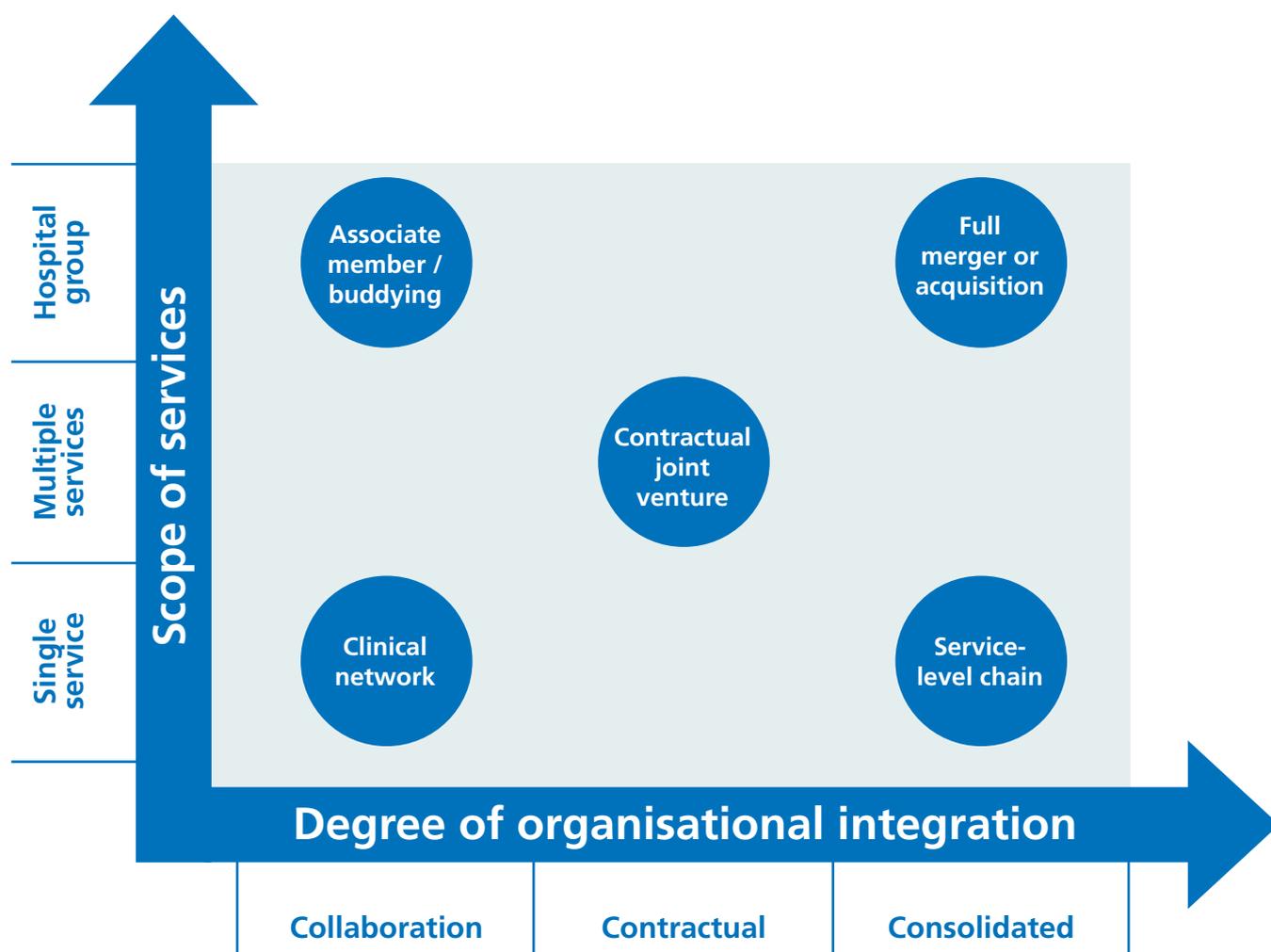
- 3.1 The vanguards have been testing a range of models to implement the collaboration strategies described in Chapter 2. Based on learning from the vanguards, this chapter:
- Describes the types of collaboration models that are emerging;
 - Explores some of the key considerations for implementing these collaboration models, including:
 - Building relationships and vision
 - Governance and decision making
 - Commissioning, contracting and regulation
- 3.2 Hospital collaborations cannot be implemented in isolation; they must be strong partners in their local health and care systems. STPs are introducing more collaborative ways of working across local systems, and in some areas supporting the development of accountable care systems (ACSs) and/or accountable care organisations (ACOs). Acute care collaborations support the development of integrated local health and care systems in a number of ways, depending on their respective objectives and geographies. For example, a hospital group might work across one or more STP or partner in a local ACS.

Types of acute care collaboration models

- 3.3 As outlined in Chapter 1, ACC vanguards broadly group into three types based on service scope: hospital groups, multi-service networks, and single-service networks.
- 3.4 For these three types, there are different models of organising which the vanguards and other acute collaborations are implementing. This reflects the various strategies the collaborations are pursuing (as described in Chapter 2) as well as the degree of business change envisaged. Building upon the Dalton Review (2014), three broad types of organisational integration can be described:
- **Collaborative** forms - bringing together two or more organisations to work together and sharing resources to achieve better outcomes for patients or financial improvements, while retaining their original legal entity. Whilst formal agreements may be needed for governance purposes, these are likely to overlay existing arrangements and individual organisations retain their own control over decision making.
 - **Contractual** forms - more formalised agreements which create legally binding rights and responsibilities between partners whilst retaining the organisational independence of individual trusts. This can include sub-contracting some services from one trust to another provider organisation, or creating a contractual joint venture, where parties formally work together without creating a separate legal entity to do so.
 - **Consolidation** forms - organisations come together to form a new entity, forming a new or merged organisation.

3.5 Figure 4 below provides a framework for the different types of collaboration model, based on the range of services in scope and the degree of organisational integration. These models are neither exhaustive nor mutually exclusive. An acute care collaboration could employ more than one at the same time. They may also progress from one type to another over time, although it is not suggested that any single model is preferential to another. As further evidence on impact emerges, this may change.

Figure 4: An illustrative framework of acute care collaboration models



3.6 As with any illustrative framework, the reality is more complex. There is much diversity in the models which vanguards are adopting and the ways they are using them. The **National Orthopaedic Alliance** is currently a collaborative clinical network sharing best practice. **Moorfields** provides networked care across 32 sites through a range of delivery models and partnership agreements including service level agreements. Models such as the **Working Together Partnership** and **Developing One NHS in Dorset** are making changes to a range of clinical and corporate services across their geography, sometimes using formal contracting arrangements. ACCs utilise different models for different purposes. For example, a hospital group can pursue consolidation between two providers whilst creating informal collaborations with

others as part of the same group. This is the case for both **Royal Free London** and **Salford Royal. Foundation Healthcare Group** is different, focusing initially on mutual partnership and joint working between Guy's and St Thomas' NHS Foundation Trust and Dartford and Gravesham NHS Trust.

Hospital Groups

3.7 The 'hospital group' (sometimes referred to as a chain) is a new arrangement that has been developed by the ACC vanguards. Individual NHS hospitals tend to be quite large (in terms of bed base) by international standards. However, to date the NHS has not seen the development of large-scale hospital groups. The main features of a group are:

- A central 'headquarters' function, responsible for providing unified strategic leadership across the whole group
- Discrete and locally managed 'operating units', which have a greater or lesser amount of devolved autonomy. Each operating unit is likely to have its own management team, responsible for operational leadership of that unit
- Standardised systems, practices, and protocols, set by the central headquarters function and reliably implemented at each operating unit
- A culture and value-set that is shared across the group and transcends individual relationships, although 'operating units' are likely to retain individual brands and identities relevant to their local population.¹⁰

3.8 NHS Improvement has accredited four foundation trusts (all ACC vanguards) to lead the development of hospital groups.¹¹ These are:

- Guy's and St Thomas' NHS Foundation Trust
- Northumbria Healthcare NHS Foundation Trust
- Royal Free London NHS Foundation Trust
- Salford Royal NHS Foundation Trust

These group leaders are developing groups in different ways, with their partnerships with other trusts ranging from buddying relationships to exploring acquisition and merger. They have been created to spread excellent practice and leadership across the NHS and all share the common goal of improving services for patients.

¹⁰ Credo Consulting (2017), NHS Group Models: Working together for a more sustainable NHS http://www.credoconsulting.com/downloads/nhs_group_models_working_together_for_a_more_sustainable_nhs.pdf.

¹¹ NHS Improvement, 'High-performing foundation trusts to support others in improving patient services' (News story, August 2016): <https://improvement.nhs.uk/news-alerts/high-performing-foundation-trusts-support-others-improving-patient-services/>.

Royal Free London's group model

Royal Free London NHS Foundation Trust acquired Barnet and Chase Farm hospitals in 2014. This took them from a single site to a multi-site trust with three separate acute sites (Barnet Hospital, Chase Farm Hospital and Royal Free Hospital).

The **Royal Free London** is establishing a hospital group across its existing acute sites with the potential to accommodate new members. It is developing ways for individual organisations to be able to join under a range of membership options, from full membership (where the member is fully owned) to 'buddying'.

The structure for the group in its current form went live in July 2017. The model comprises a Group Centre, autonomous hospital units and Clinical Practice Groups (which reflect the four divisions within the hospital group):

1. Group Centre

A corporate centre supports hospital units through strategic functions including analytics, workforce development and strategic decision making. It also monitors and directs the operating units to ensure they meet group objectives.

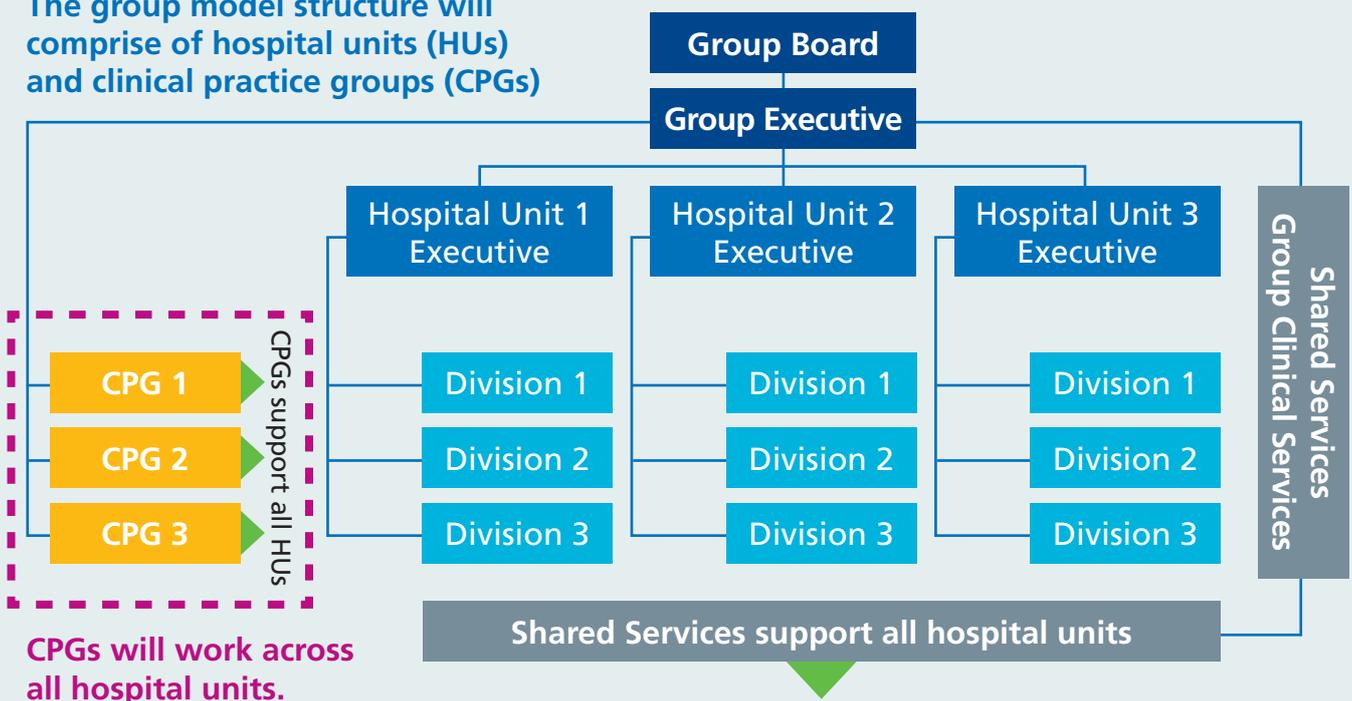
2. Hospital Units (HU)

One or more hospital sites run together as a single operational unit. Each unit has devolved responsibility for day-to-day operations and decision-making. Each unit has a strong clinical and operational leadership team.

3. Clinical Practice Groups (CPGs)

CPGs bring together groups of clinicians and managers from each of the hospital units - and they have responsibility for defining standardised clinical processes and pathways which are then implemented across each Hospital Unit.

The group model structure will comprise of hospital units (HUs) and clinical practice groups (CPGs)

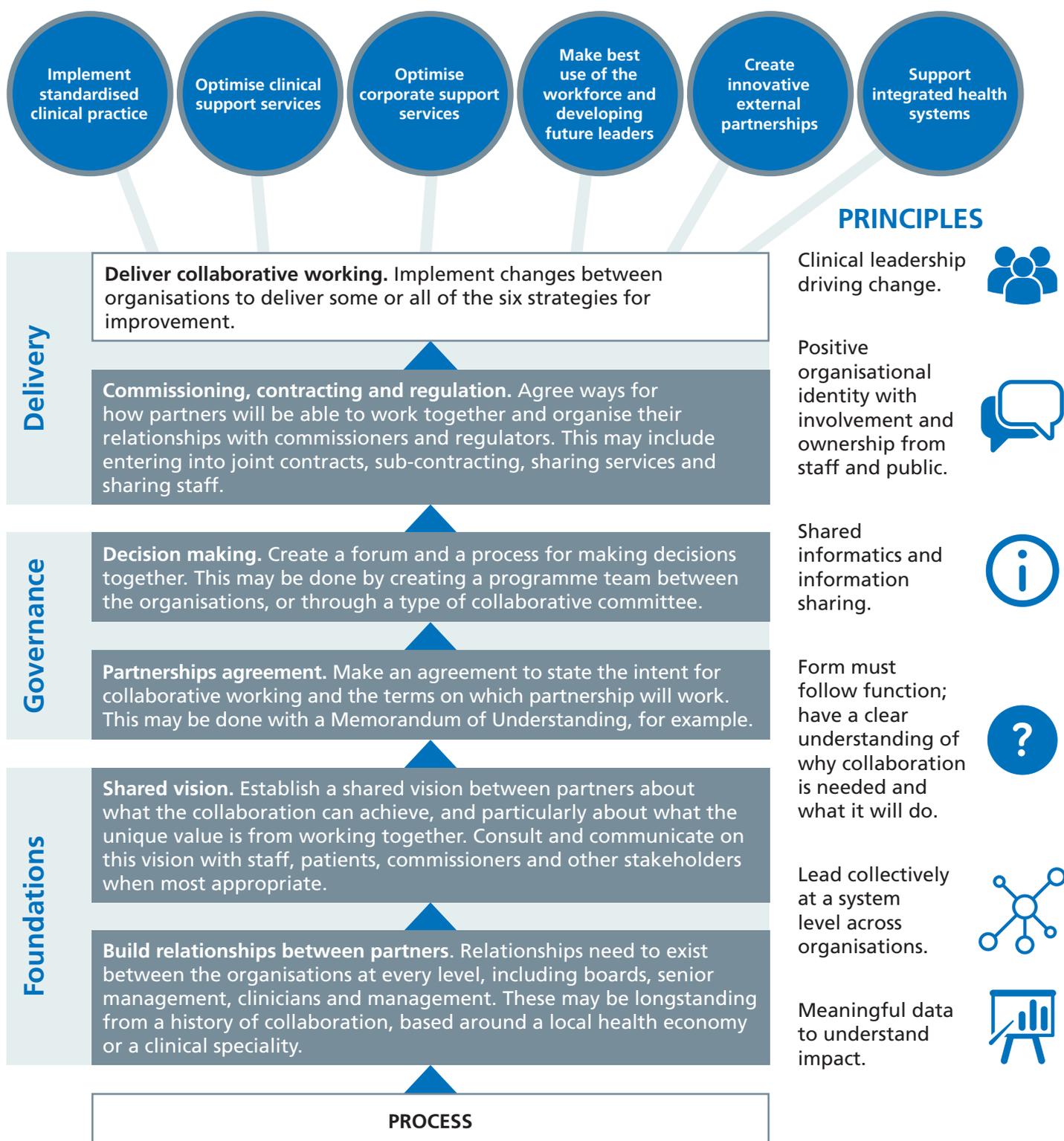


CPGs will work across all hospital units.

Implementation considerations

3.9 The following section considers some of the key steps in implementing these different models. Figure 5 below summarises the key issues.

Figure 5:



Building relationships and vision

- 3.10 Successful long term collaborations come about as a result of strong relationships and a clear purpose about what a partnership can achieve. This should be the starting point for collaborations rather than a primary focus on organisational structures; form follows function. The vanguards have made most progress when they have developed good relationships between partners and started with a clear vision about what their collaboration can achieve (the six strategies described in Chapter 2) before planning their organisational form.
- 3.11 The ACCs have had different starting points for building their relationships. Some have had longstanding collaborations whereas others have had limited formal partnership working. For example, the seven trusts which make up **Working Together Partnership** have worked together at a strategic level for many years in Yorkshire and Derbyshire. A formal partnership was then created in 2013 before becoming a Vanguard in 2015; both of which have served to increase the ambition and pace of collaborative work. Other vanguards, such as **MERIT**, for example, do not have as much history of strategic partnership working. As a result, time is needed to develop relationships and agree ways of working to then make significant progress.
- 3.12 Learning from the vanguard programme it is clear that having a shared vision across the group or network is crucial to building a successful collaboration. For all of the vanguards their purpose is based upon delivering a number of the six strategies described in Chapter 2. All partners must have a common understanding of their aims and how working together can add unique value to achieving them. **Foundation Healthcare Group** is an example of a collaboration taking dedicated time to build relationships and develop a vision. At the beginning the executive teams examined their shared challenges and common organisational values. Executive teams and clinicians then considered clinical opportunities and potential benefits of collaboration, creating a shared vision based upon combining the size and influence of a large teaching hospital with a district general hospital to support local, sustainable services. The vision was tested with a variety of stakeholders, including patients and carers, governors, clinicians and commissioners. Following this, in April 2016 the two trusts signed a Memorandum of Understanding (MoU) to set out the principles of partnership working. This has formed a foundation for developing the vanguard.¹²
- 3.13 In addition to relationships within the vanguard partners, building relationships with external partners is crucial. This is particularly the case where there are local accountabilities. Effective and sustainable acute collaborations depend upon involvement of the public, commissioners and governors in both the creation of the partnership vision and design of its organising form. If the collaboration is to introduce significant changes it needs the involvement and ownership of those who can hold it to account. There then needs to be clarity about where accountability lies; patients and communities should know who can be held to account for the services they receive. For example, the **MERIT** vanguard has created a 'ME in MERIT' initiative to create a network of experts by experience across the West Midlands to help public engagement across each of the MERIT work streams. The vanguard has also established a non-executive director assurance group consisting of one non-executive director from each trust.

12 Dartford and Gravesham NHS Trust and Guy's and St Thomas' NHS Foundation Trust, (2017) 'Foundations for change: The development of the Foundation Healthcare Group 2016/17' <http://www.guysandstthomas.nhs.uk/resources/innovation/Vanguard-End-of-Year-Report.pdf>.

Governance

(i) Partnership agreements

3.14 To formalise collaborations an agreement between partners is needed. This is most commonly done through a Memorandum of Understanding (MoU). A MoU provides an overarching framework for collaborative working between two or more trusts by setting the terms of the partnership and expressing shared objectives and actions between partners. MoUs are not usually legally binding and do not give obligations to either partner. However they can be a first step to creating legal contracts and some elements included within it (such as confidentiality provisions) may have a legal basis. Most of the ACC vanguards have signed MoUs as part of initiating their collaborations. MoUs should be reviewed regularly and updated as collaborations progress.

Case study

Building the EMRAD consortium

The East Midlands Radiology (**EMRAD**) consortium is a partnership which has grown from a joint procurement opportunity to a clinically-led network which is attracting international interest. Building trusting relationships across its eight member trusts has been fundamental to this success.

Initially member organisations were not used to working together and did not always operate as a cohesive group. Technical issues with implementing the new system and the delay of the 'go live' process in Nottingham were particularly challenging. This had the potential to cause divisions in the fledgling consortium. Instead all parties rallied around the objective of building a system that worked. Rather than turning against each other, the consortium adopted a problem solving mind-set and continued to work through the challenges together. The consortium has also expanded, with Burton Hospitals NHS Trust joining to make it a membership of eight.

Each subsequent roll-out of the new system became easier as lessons were learnt and problems solved collectively. All of the consortium members acknowledge that this represents a significant shift in attitudes and behaviours from where they began.

The EMRAD model is underpinned by information governance agreements, a co-ordinating agreement and a central co-ordinating office. However it is the relationships rather than the structures or agreements that really hold it together.

The partnership working required for the joint procurement has helped to develop closer working relationships between consortium members and a culture of trust between staff. The culture has enabled the consortium to develop and innovate in a range of different ways, which go beyond the original vision for the partnership.

Working Together Partnership Governance – Committee in Common

Working Together Partnership is a federation of seven hospital trusts from South Yorkshire, Mid Yorkshire and North Derbyshire. The trusts are working under a joint working agreement to implement managed clinical networks, standardise practice, improve informatics and generate efficiencies across clinical and corporate services. To govern these joint-working arrangements the partnership has established a collaboration committee, known as a Committee in Common.

The Committee in Common model involves each partnering organisation setting up its own committee. Decisions are delegated to the committees according to the services listed in a joint working agreement between the seven trusts. The respective committees have identical membership and meet with the same agendas at the same time. They are not formally a joint committee but instead help the partnership to coordinate decision-making without the need to establish a new legal entity. Each committee remains accountable to its respective board. The trusts remain as seven separate legal entities with their own accountabilities and responsibilities.

The establishment of this type of model could be tailored for a range of shared joint working arrangements and might be a transitional step in some instances to a more formal organisational model.

3.15 Membership models can create agreements between single-specialty providers in a network. This is used by the **National Orthopaedic Alliance**. Members pay to join the alliance and are able to access evidence based standards for orthopaedics. By being a member, providers agree to adhere to a codified set of standards, protocols and processes. The collaboration also has an overall focus on continuous quality improvement and safety and it has a set of benchmark targets for all members to meet. There is good potential for versions of this membership model to be applied to other speciality areas.

(ii) Decision making

3.16 When embarking on a collaborative venture, appropriate governance mechanisms for decision making between providers are important. This helps to establish clear roles, accountability and decision-making processes. For formal collaborations governance arrangements will be needed to manage items such as membership terms, voting, scope of decision making and conflict of interest management.

3.17 In many instances, creating a forum across organisations in the collaboration, such as a working group or programme board, has been sufficient for vanguards. This has been common in the initial stages of a partnership, where the programme may be in development and its scope may be smaller. In some cases it has been underpinned by a MoU, for example in both the **EMRAD** and **MERIT** vanguards.

3.18 A more developed governance arrangement that some vanguards and other partnerships (such as Mid and South Essex) are exploring is a 'collaborative committee'. These are sometimes referred to as 'committees in common'; where nominated members from the individual partner organisations meet together at the same time to reach agreement on behalf of their sovereign organisations. For this to operate partner organisations including NHS Trusts and Foundation Trusts need to delegate (within the scope of their permitted delegations) the ability to make decisions to their relevant nominated member. Decisions are made (in accordance with the delegation) by the nominated members on behalf of their organisations. If the delegations are not in place or are not workable, nominated members of the committee would need to take the discussion back to their organisation for a decision to be made. Care is needed to ensure that boards (particularly the non-executive members) are engaged in the new arrangements, although it is expected that this is established and managed as part of the delegation process. The partner organisations need to ensure decisions are documented appropriately and keep track of their governance arrangements.

Moorfields' Networked Care Model

Moorfield's Eye Hospital NHS Foundation Trust is a provider of eye health services, currently delivering services from a network of 31 sites in the UK. In this model all care is delivered directly by Moorfields, operating under unified corporate and clinical governance frameworks. Staff and resources are paid for and managed directly by Moorfields at most of the network sites, and more of the activity is commissioned directly from Moorfields. Host trusts are not directly involved in the clinical service delivery once Moorfields has taken over responsibility for the service. Service level agreements (and/or leases and licences of occupation) underpin local clinical support or support services, provided to or by the host trust or landlord. The networked site services are part of the Moorfields organisation and responsibility for patient care and governance clearly rests with Moorfields at the majority of the locations.

The Moorfields vanguard programme carried out an extensive review of the Moorfields network and collaborated with other single specialty network providers to test the hypotheses as to "whether the longer term sustainability of single speciality services in smaller hospitals can be strengthened by entering into a network partnership and what benefits that might bring".

This learning is available in a unique, easily accessible, online learning resource - www.networkedcaretoolkit.org.uk. The aim of this toolkit is to help other organisations to consider and replicate the networked care model using the evidenced learning, tips, tools, videos and practical templates provided.

Commissioning, contracting and regulation

(i) Commissioning and contracting

- 3.19** Many of the ACC vanguards are collaborative forms and therefore do not require significant changes in commissioning and regulation. However some do use contractual models for working together and these create legally binding rights and responsibilities between partners whilst retaining the independence of individual trusts.
- 3.20** Contracting between providers takes place in a number of ACCs which are sub-contracting work or sharing services. In a sub-contractor model, one trust sub-contracts some of its services (clinical or administrative) to another provider organisation. The host trust maintains the relationships and accountability with the commissioner, but sub-contracts responsibility for providing the relevant services to another provider. **Moorfields** provides its care across multiple sites in this way. A contractual joint venture can enable providers to work together to provide shared services without needing to establish a new legal entity. A shared pathology service is an example of a shared service between acute providers which can use a contractual joint venture. This is being explored by **Developing One NHS in Dorset**.
- 3.21** Contractual models can be used to formalise partnerships between providers. For larger scale change, alliance arrangements can be made as umbrella agreements between a commissioner and a number of providers. The alliance may be an agreement in a similar way to a MoU, or be a contractual mechanism. Commissioners still hold separate service contracts with each provider but the alliance agreement serves as a mechanism to bind together providers and commissioners around shared objectives and actions. They typically describe the purpose of the alliance, expected outcomes, ways of working, the roles of each partner, and governance arrangements to oversee delivery. NHS England has developed a draft alliance agreement for commissioners and providers that wish to develop PACS and MCP models of care without having a single contract with a single provider.¹³ The principles in this alliance agreement may be relevant for some ACCs and the draft agreement can be used as a template to facilitate discussions between commissioners and providers.
- 3.22** The larger and more formal the changes which result from partnerships, the more commissioner involvement and leadership are required. Providers can collaborate on many aspects of services and business without altering the underlying contractual agreements with commissioners. Whatever the new model of care adopted, CCGs and NHS England direct commissioning remain accountable and cannot delegate the exercise of their statutory functions. However they can contract for services in ways which encourage collaborative working and shared services between providers. This can be done either by commissioning services from a lead provider, which then sub-contracts with other providers for some services, or through an alliance agreement (as described above). In making commissioning and contracting decisions, commissioners must make sure they follow procurement law, in particular by being open and transparent in advertising their intention to enter into new contracting arrangements.

¹³ NHS Standard Contract Template Alliance Agreement for Virtual MCP/PACS models <https://www.england.nhs.uk/wp-content/uploads/2017/08/3b.-170802-Alliance-Agreement.pdf>.

3.23 Whilst the majority of ACCs have not resulted in changes in organisational form, any partnership considering significant contractual change or consolidation needs to consider other items including the following, for which bespoke advice will be required:

- Employment and pensions
- Ownership of companies and joint ventures
- Tax and VAT
- Public engagement and consultation
- Competition and choice
- Information governance

Case study

Vanguard and future commissioning models

The **Cancer Vanguard** is made up of cancer alliances from three regions; Greater Manchester, North Central and North East London, and North West and South West London. Across the vanguard different ways of changing the commissioning and organisation of cancer services are being explored to support a more integrated approach to cancer care. The three areas are different types of system, with North Central and North East London led by a multi-specialty tertiary centre, North West and South West London led by a specialist cancer trust and Greater Manchester working within a devolved health economy and single STP footprint. This means models and pathways can be tested and adapted for each context.

The vanguard is collaborating on pathways and associated commissioning and contracting models to reduce the fragmentation which can exist within cancer pathways. Each system is exploring models in which a single organisation would be accountable for the delivery or commissioning of cancer services for the whole population. Either a lead provider would sub-contract with other providers and be responsible for system performance, or a single commissioner would commission cancer services for the population.

It is envisaged these models will improve patient experience by ensuring the implementation of integrated and efficient pathways, improve outcomes through earlier diagnosis and more timely treatment and improve financial performance by reducing variation and duplication. These models are in a phase of planning and development in each system, and the scale and status of the Cancer Vanguard means that they are fulfilling a system leadership role.

There are challenges in designing some of these reforms to commissioning models. This includes getting an understanding of what constitutes 'cancer spend' given the overlap with other conditions and the practicalities of coding in diagnostics. This can make it difficult to develop whole population and capitated approaches to funding, given the size and associated risk from cancer spend. To help solve this, the vanguard has been defining what should be included in data collection for cancer and improving the availability and timeliness of data across organisations.

(ii) Regulation and oversight

- 3.24** As the provider landscape changes with organisations working in new collaborative models, oversight and regulation will need to adapt accordingly. NHS Improvement and the Care Quality Commission (CQC) take leadership in these areas and are adapting their approaches as new care models become more defined.
- 3.25** Most acute care collaborations are unlikely to require formal review by NHS Improvement because they do not involve new organisational forms or significant changes in the scope of services provided by a trust. In February 2017 NHS Improvement published advice on oversight for new models of care.¹⁴ This document includes advice for trusts considering innovative organisational forms or significant diversification.
- 3.26** Where acute providers are partnering together, NHS Improvement will continue to licence and oversee separate legal entities in line with its statutory duties. Most of the ACC forms outlined above do not create separate legal entities, and therefore NHS Improvement will continue to oversee individual trusts which each hold separate provider licences. Hospital groups can include a number of providers and may use a variety of membership models, ranging from buddying through to full acquisition. Should the trusts involved become a single legal entity through merger or acquisition, they will be legally accountable as a single organisation, with a single provider licence.
- 3.27** To reflect the potential changes to organisational structures, CQC is developing its approach to the registration and monitoring of providers and have consulted publicly on these changes. Provider registrations will include all those with accountability for care in addition to those that directly deliver services. This means that where one organisation has multiple legal entities, the CQC hold accountable the central entity directing or controlling activity even if they are not directly delivering care. Taking this approach will enable the public to be well informed about accountability for the ownership and delivery of services. It will also improve the understanding of large and complex organisations to enable a more targeted and responsive approach to regulation. CQC will work closely with trusts changing their models, to understand the implication for registration and inspection, and support the resulting regulatory process with CQC.
- 3.28** In addition, the CQC is aligning its inspection processes with NHS Improvement to minimise complexity and increase the efficiency for providers delivering different types of services across different locations. CQC and NHS Improvement will use the same framework to assess how well led a trust is, to ensure consistency. They are also developing ways to ensure providers are not penalised for taking over poorly performing services. This could otherwise be a limiting factor in the expansion of hospital groups and needs to be mitigated where possible, whilst maintaining the need for regulatory intervention by CQC where there is a risk of poor care. This is in line with CQC's principles for regulating new and complex models.

¹⁴ NHS Improvement (2017), Oversight of new care models https://improvement.nhs.uk/uploads/documents/New_care_model_oversight_-_key_issues_V2_15-08-16_updates_-_sbv2_edNS_final.pdf.

4. Measuring the benefits of Acute Care Collaborations

Evaluating the ACCs

- 4.1 Evaluation has been central to the New Care Models programme and provides the main source of evidence about its benefits. The approach taken to evaluation of the ACCs has been slightly different to the other care model types. Like the Multispecialty Community Provider (MCP) and Integrated Primary and Acute Care System (PACS) vanguards, each ACC vanguard has appointed an independent local evaluator. However, unlike in MCPs and PACS, there is no common national set of outcome metrics. This is because the ACCs represent a diverse range of models. In particular, the majority of ACCs are focused on one clinical speciality, meaning hospital-wide metrics are insufficiently sensitive. Whilst this represents a fertile opportunity for innovation, it creates challenges for assessing benefits across the cohort.
- 4.2 Instead, each vanguard was asked to identify a set of locally-appropriate metrics. These were analysed to create a thematic framework for the ACC programme. Each vanguard was then asked to supply a metric for each theme, where appropriate. It is hoped this framework may provide a useful basis for future evaluation of collaboration between hospitals.
- 4.3 In addition, a range of national data sources – including the Model Hospital and NHS England’s Acute Care Quality Dashboard – were assessed to identify whether there were any relevant nationally-produced metrics. None were identified that would apply to the entire cohort, but three – cost per weighted activity unit (a measure of the unit cost of care), inpatient Friends and Family Test, and Referral to Treat Incompletes – are being measured for the four hospital groups (**Royal Free London, Foundation Healthcare Group, Northumbria and Salford**). This reflects the commonality in what the four groups are trying to achieve.
- 4.4 Limited evidence has so far emerged on measurable benefits. This reflects the fact that many of the vanguards are still at a relatively early stage of implementation. Local evaluations tend to focus more on describing and analysing how change has occurred, what is working, and what is not, rather than the outcomes that have been achieved. In addition, October 2017 was the first submission of local metrics. Data collection methods and coverage are likely to improve for the next quarter as more metrics come on stream.

A framework for measuring acute care collaborations

- 4.5 The metrics associated with acute care collaborations cluster into four themes, and twelve associated sub-themes. These are outlined in Figure 6 below. The vanguards report between 1-3 metrics against each theme, or provide a reason why it would be inappropriate for them to measure this (for example, because the vanguard is not implementing any interventions that will affect that outcome). Figure 7 gives an illustration of some of the specific measures vanguards are using.

Figure 6: Local and national metrics themes

Overall themes	Local metric themes	National metrics (for Hospital Groups only)
Improved patient access and experience	Improved patient experience	Improvement/ maintenance of Inpatient Friends and Family Test
	Care closer to home	N/A
	Reduction in waiting times	Reduction in Referral to Treat Incompletes
Reduction in unwarranted variation	Reduction in unwarranted variation	N/A
	Shifting the setting of care	N/A
	Improved sharing of information between providers	N/A
Workforce	Improved staff recruitment and retention	N/A
	Reduction in the use of agency staff	N/A
Efficiency	Mainly picked up through local evaluations	Improvement in the unit cost of care (Cost per Weighted Activity Unit)

- 4.6 Below is presented some excerpts from the first set of metrics received from vanguards. Care should be taken in interpreting these findings as the metrics are at an early stage of development, and are generally presented without contextual information, meaning attributing changes to the vanguard is challenging.
- 4.7 Findings from local evaluations are also included. All take a more holistic approach than local metrics, triangulating findings from different sources to produce more robust conclusions about what works, for whom, and in what circumstances.

Early findings by theme

Improved patient access and experience

Improved patient experience

- 4.8 Metrics on this theme primarily relate to specialty-specific Friends and Family Tests (FFTs) and inpatient FFT (for the Hospital Groups). FFTs are generally being used to assess how improvements in efficiency or service reconfigurations are impacting on the experience of patients, and their perception of services. In addition, some vanguards are using locally-developed surveys to collect feedback on individual service innovations, to understand their acceptability and outcomes for patients.

The **Neuro Network** has used locally-developed surveys. These show that nearly all patients are satisfied with the nursing advice line (91%) and Integrated Neurology Nurse Specialist (96%) projects, though satisfaction with satellite services is slightly below target (82% satisfied against a target of 95%).

4.9 Developing One NHS in Dorset has tracked FFT for Maternity, Cardiology Inpatient and Ophthalmology Inpatient. For all, performance remains near the national baseline (95%), so there is limited evidence of any impact (positive or negative) of the vanguard thus far.

4.10 The national inpatient FFT offers no clear evidence yet in relation to any impact from the hospital groups.

Care closer to home

4.11 A number of the ACCs are looking to shift care settings. This shift is primarily about offering more specialist care closer to patients' homes – either through primary care, or through offering clinics in district general hospitals and other non-tertiary centres.

4.12 For example, **Foundation Healthcare Group** are aiming to shift more specialist care away from Guy's and St Thomas' NHS Foundation Trust closer to patient's homes in Dartford and Gravesham. Local metrics data suggest that this has saved 21,000 patient miles since November 2016, with 478 patients having appointments at Dartford and Gravesham NHS Trust that would otherwise have been at Guy's and St Thomas' NHS Foundation Trust. Likewise, and though small in number, eight patients have received denosumab through self-administration in the initial pilot by the **Cancer Vanguard**. This has meant that those patients have not had to attend hospital to receive their treatment, and the pilot is now being rolled out further.

Managing more patients in primary care: Neuro Network's Consultant Advice Line & Headache Pathway Project

Neuro Network's Consultant Advice Line (CAL) provides GPs with direct telephone access to neurology consultants. This should reduce the need for outpatient referrals. Of 181 calls received, 52% were resolved without the need for an outpatient attendance, and were instead managed in primary care. The vanguard calculated cost savings on the basis of this, suggesting that these each represented an avoided outpatient attendance, and thus saved a total of £17,202. **Scaled up over a year, this could result in a potential saving of £88,000.**

Some care should be taken with this data. The cost savings are based on the assumption that all calls 'resolved' would otherwise have resulted in an outpatient attendance, which has not been proven. In addition, the potential savings have yet to be mapped against the cost of delivering the CAL.

The Headache Pathway Project embedded a new approach to assessing headaches for GPs, assisting them to make the right decision about whether to refer patients with a headache or migraine to specialist neurology services. Early findings suggest that **between 2015/16 and 2016/17 there was a 9% reduction in referrals to secondary care.**

This is encouraging but the lack of comparison means analysis currently cannot rule out that something else might have caused this decline. We also do not know whether this reduction in referrals also resulted in a reduction in A&E attendances (the project's ultimate outcome).

Source: Neuro Network (2017) Tranche 2 Independent Evaluation Report (available on request at england.newcaremodels@nhs.net)

Waiting times

- 4.13 Two-thirds of ACCs are aiming to improve waiting times for target specialties. Primarily, this is being measured through the proportion of those waiting for treatment for more than 18 weeks, for target specialties, or 2-week/62-day waits for cancer. Progress across the ACCs is mixed: some are on track (**Cancer and Foundation Healthcare Group**), though for **Cancer** this primarily reflects historical high-performance. Conversely, all of **Developing One NHS in Dorset's** RTTs (for gynaecology, ophthalmology and cardiology) are potentially deteriorating, which the vanguard reports reflects staff shortages.
- 4.14 It is difficult to discern trends in the RTT data across all the hospital group vanguards and there is not yet any clear evidence of vanguard activity affecting this.

Reducing unwarranted variation

Reduction in unwarranted variation

- 4.15 Most vanguards are reporting metrics around reducing unwarranted variation, reflecting that standardising (and optimising) care across different sites is a key aim of the ACC programme. Primarily, these metrics are outputs – aimed at measuring the activities needed to reduce unwarranted variation, rather than measuring outcomes for services or patients. This reflects the stage of implementation. The focus on outputs means there is little consistency across the cohort.

Output metrics show vanguards are: standardising reporting fees for radiologists and radiographers across participating trusts (**EMRAD**); implementing county-wide referral criteria, and improving access to paediatric consultants (**Developing One NHS in Dorset**); improving the rate of spinal procedures and surgery, and reducing the number of headache referrals (a 9% reduction in referrals to the Walton centre in the **Neuro Network**); and improving weekend access to paediatric consultants (**Working Together Partnership** now provides a separate ENT specialist paediatric rota for Sheffield Children's Hospital which the Chesterfield Royal Hospital consultants contribute to).

Shifting the setting of care

- 4.16 Around half of the vanguards are reporting metrics around shifting the setting of care. Metrics within this theme are similar to those in the 'care closer to home' theme, however, the focus is different. Rather than the aim being to simply offer care closer to patients' homes, the focus is on ensuring the best quality (generally consultant-led) care is available to all patients, in a way that is financially sustainable. In some cases, this means concentrating care in fewer sites, meaning patients will travel further for treatment. For example, in **Working Together Partnership** over 90% of Chesterfield Royal Hospital ENT weekend emergencies are now being transferred to Sheffield. Previously, they would have been treated at Chesterfield Royal, where there is no consultant-led specialist service.

Improved information sharing between providers

- 4.17 Most vanguards are reporting metrics on improved information sharing between providers. Metrics in this theme are particularly varied, and include:

Case study

Improved information sharing between providers: MERIT's shared bed management system

The **MERIT** shared bed management system has not yet been fully implemented. However, even without full implementation, bed managers report that the improved relationships developed as part of the programme has meant that they have begun to informally allocate beds from within the MERIT trusts. This has resulted in seven patients being admitted to another MERIT bed, who would previously have been sent out of area – **saving a total of 93 out of area bed days**. It is expected that once the system is fully implemented the impact will be significantly larger.

Source: Mental Health Strategies (2017) MERIT Vanguard Evaluation report (available on request at england.newcaremodels@nhs.net).

- **Neuro Network** demonstrating uptake and use of the new Consultant Advice Line (sharing expertise between consultants and GPs)
- The **Cancer Vanguard** showing 359 users of pan-vanguard informatics and 15 sites signing up to using shared data collection tools.

Workforce

Staff recruitment and retention

4.18 Improving the recruitment and retention of staff is a key focus for many ACCs, with two-thirds reporting a metric against this theme. Some metrics relate to the vacancy rate or turnover in key professions. For example, the **Neuro Network** is measuring the consultant neurologist and specialist nurse vacancy rates; both are potentially deteriorating. Other metrics relate to staff wellbeing or satisfaction. For example, in **EMRAD** 77% of respondents to local surveys either agreed or strongly agreed that their work/life balance had improved as a result of home-based ability to read scans.

Reduction in the use of agency staff

4.19 Reducing the use of agency staff is a focus for the majority of the vanguards. Most sites are assessing this through looking at total or percentage change in agency spend. For the three sites reporting data:

- **EMRAD** has saved about £90,000 in the first year of operation through in-sourcing rather than outsourcing radiology imaging reading (excluding the cost of setting up the service)
- **Developing One NHS in Dorset** and **MERIT** have reduced agency spend by 21% and 20% respectively, compared to this time last year. Care should be taken in interpreting this, given the relatively short trend time.

Efficiency

4.20 Efficiency is primarily measured by vanguards' local evaluations. This reflects that assessments of changes in efficiency are generally quite complex, requiring more detailed primary research and economic modelling than is possible in local metrics data. An example of a local evaluation's economic modelling (from **EMRAD**) is below:

Case study

Generating financial savings: an example from EMRAD's local evaluation

EMRAD are aiming to deliver financial savings from their new model by increasing the amount of radiology reading that is insourced (read by employees of the trust, rather than outsourced to private contractors). EMRAD's investment in the regional imaging system should make it cheaper for them to insource image reading, as the level of investment in equipment cannot/has not been matched by commercial organisations. The new service should also reduce waiting times for patients.

The overall financial impact is not yet clear. The most conservative ex-ante modelling suggests the service will be roughly cost-neutral (**net cost of £400,000 over 10 years**). This cost neutrality should be associated with an increase in quality. For example, waiting times should reduce, and there may also be improved workforce satisfaction due to more flexible working. However, there is not yet evidence of this increased quality.

There are some limitations to this analysis. Savings were primarily driven by the difference in cost between insourcing and outsourcing radiology imaging reading (129% of insourcing cost). However, this modelling is based on assumptions about the percentage of outsourced activity, the way in which this increases, and the differences between the insourced and outsourced tariffs. Changes in any of these would significantly alter the results. Next year, EMRAD will therefore refine the analysis as evidence emerges on how much activity is outsourced, and tariffs become clearer. This could result in significant increases, or decreases in savings accrued.

Source: Optimity Partners & Methods Advisory (2017) EMRAD Evaluation Report (available on request at england.newcare.models@nhs.net).

4.21 In addition, cost per weighted activity unit (WAU) for each of the hospital groups is being monitored. An improvement in the cost per WAU should indicate that trusts are delivering the same care, with fewer resources. However, the metric looks at the performance of the entire trust, whereas the focus for the hospital group vanguards (at least initially) is on specific specialties or service lines. As a result, this measure may not be particularly sensitive to change.

Figure 7: ACC metrics framework: examples of metrics used

		Example metrics
Improved patient access and experience	Improved patient experience	Speciality-specific Friends and Family Tests (multiple) Locally developed surveys (multiple)
	Care closer to home	Reduction in distance travelled to appointment (Foundation Healthcare Group) Increase in home birth rate (Cheshire & Merseyside) National Cancer Patient Experience survey Q53 – Did the GPs and nurses at your general practice do everything they could to support you while you were having your cancer treatment? (Cancer)
	Waiting times	RTT incompletes (multiple) Cancer 2 week/ 62 day wait (multiple) Waiting times for specific/ new clinics (multiple)
Reduction in unwarranted variation	Reduction in unwarranted variation	Number and rate of spinal pain injection procedures by hospital and by CCG and per 1,000 population (Neuro Network) Number of new clinical pathways in place and monitored at one or more hospital site (Royal Free London) More than 50% of children across the county seen by paediatrician within four hours (Developing One NHS in Dorset)
	Shifting the setting of care	% patients transferred to consultant-led hub service at weekend (Working Together Partnership) Number of patients admitted to another MERIT trust bed (MERIT)
	Improved sharing of information between providers	Number of staff with access to service users' care records across all MERIT organisations (MERIT) National Cancer Patient Experience Survey Q54 – Different people treating you worked well together to give the best possible care (Cancer) Providers submitting data to SCN maternity dashboard (Cheshire and Merseyside)
Workforce	Improved staff recruitment and retention	Staff turnover rate (multiple) Vacancy rate for nurse specialist and consultant posts (multiple) Staff engagement and satisfaction scores (multiple)
	Reduction in the use of agency staff	Change in agency spend as a proportion of total staff spend (Royal Free London) Total spend on agency staff (multiple)

5. Conclusion

- 5.1 The 13 Acute Care Collaboration vanguards demonstrate the range of opportunities for hospital collaboration in the NHS. They have implemented a range of collaboration strategies from standardising clinical practice to making creative and efficient use of their workforce talent. To support the implementation of these strategies, the vanguards have prototyped a range of new partnership arrangements, from collaborative networks for individual clinical specialties to fully integrated hospital groups.
- 5.2 In the majority of cases these models are still in their infancy; as such the implementation lessons are still emerging. What is evident is that a clear shared vision and trusting relationships between partners is the prerequisite for progress. For maximum impact there must be clinical leadership driving change with involvement and ownership from staff and the public. Focused outcomes, good data and critical reflection are necessary for meaningful improvement.
- 5.3 The evaluations of the vanguards are ongoing which mean that measurable benefits are so far limited. Whilst the 13 vanguards are diverse, their measures of success cluster in four areas: improving patient access and experience; reducing unwarranted variation; solving workforce challenges; and improving efficiency. Some promising results are emerging from the individual vanguards. However, given the long-term ambitions of the collaborations it remains too early to make generalisable conclusions on measurable benefits across the whole programme.
- 5.4 A number of wider policy and implementation issues have emerged during the course of the programme that will require further work to reach firm conclusions on:
- The vanguards demonstrate types of organisational models, but it is not yet clear in what circumstances these models might be most effective. For example, do the lessons from single speciality networks, such as **Moorfields**, transfer to other specialties? Is it practical and desirable for hospital groups to spread to non-geographically adjacent areas as they have done in other countries?
 - The potential to spread the models further is uncertain in some cases. The direct replicability of some of the models may be limited because of their unique nature, for example the **Cancer Vanguard** and the **Neuro Network**.
 - It also remains to be seen how some hospital collaborations will combine with population-based new care models, although places like **Salford** and **Northumberland** are beginning to show how this may be possible.
 - The opportunities for hospital collaborations to look quite different by making greater use of digital and other technologies have not been fully realised by the vanguards. For example, specialty networks that exploit remote technologies may help sustain smaller hospitals with service and workforce challenges.
- 5.5 As the NHS transitions to a greater focus on working in more integrated local health and care systems, acute services must continue to work more collaboratively. Sustainability and Transformation Partnerships and Accountable Care Systems have the opportunity to build on these models, test them further and determine how they can support other new care models. Whilst hospital groups may have a particular role to play in standardising acute care within local systems, specialty networks in their different guises have the potential to develop further regionally and nationally.
- 5.6 Regardless of their form, it is clear that acute provider collaboration will remain vitally important in improving care for patients and securing the sustainability of the NHS. Now more than ever no hospital can be an island.

Appendix A: The ACC Vanguards

Hospital Groups

Foundation Healthcare Group

Partners:

Guy's and St Thomas' NHS Foundation Trust is an accredited group leader and has begun a partnership with Dartford and Gravesham NHS Trust.

What are they doing?

The Foundation Healthcare Group is looking at how a tertiary provider can work with a district general hospital to improve quality and financial sustainability of services. Guy's and St Thomas' is developing a local hospital model to improve the financial sustainability of Dartford and Gravesham through standardising practices, improving effectiveness and sharing resources. The model is potentially replicable across the NHS and demonstrates how smaller local hospitals can gain the benefits from affiliating with a hospital group whilst retaining local accountability and relationships. Patients continue to receive the majority of their care at Dartford and Gravesham whilst closer joint working and information sharing with Guy's and St Thomas' helps any transfer for more specialist care to be more timely and efficient. For staff in each organisation the model enables them to access mutual support and share assets and skills.

Business Model

The vanguard believes a collaborative, non-acquisitive model will allow patients to benefit from the knowledge, care and resources in both trusts without the political, legal and financial challenges of an acquisition. The vanguard operates under a memorandum of understanding signed between the two trusts in April 2016.

Patient population:

1.25 million.

Website:

www.dvh.nhs.uk/about-us/vanguard/

Northumbria Foundation Group

Partners:

Northumbria Healthcare NHS Foundation Trust is an accredited hospital group leader and is the founding member of Northumbria Foundation Group. The group is open to appropriately aligned organisations joining it.

What are they doing?

Through the hospital group Northumbria Healthcare NHS Foundation Trust will spread its knowledge and excellence to other parts of the NHS. The hospital group offers a range of clinical and corporate support services together with best practice standard operating models that are designed to drive up the quality of care and reduce variation in services.

Business Model

Northumbria Foundation Group is developing a membership model with a broad portfolio of services and partnership options, ranging from consultancy support to contracting and consolidation. Partnerships support all organisations to either generate income or make efficiencies and can support better patient care by using standard operating models. This might in the longer term lead to more formal integration between organisations but the main focus of the model operates without material changes to accountability or governance arrangements as it uses management contracts. The group will include a number of strategic partnerships across the public and private sectors.

Patient population:

520,000.

Website:

www.northumbriafoundationgroup.nhs.uk

Royal Free London

Partners:

The Royal Free London NHS Foundation Trust is an accredited hospital group leader. North Middlesex University Hospital is joining the group, initially as a 'clinical partner'. West Hertfordshire Hospitals NHS Trust is exploring specific areas on which to collaborate to deliver quality and financial benefits.

What are they doing?

The Royal Free is planning to create a hospital group with potential for between 10-15 NHS trusts, which is connected by a single group centre, as well as common processes, governance, and back office systems. Organisations can join the group under a range of 'membership options' suitable to their circumstances from full membership (where the member is fully owned) to 'buddying'.

Business Model

The vanguard is exploring different ways for a number of trusts work together under a single group structure. Whilst some members will join via collaborative or contractual agreements, other members may join through formal merger and acquisition. Each operates within an organisational structure where there is separation of strategic management, in a group headquarters, from operational management at each managed entity or business unit.

Patient population:

5 million
(vision for up to 15 group members).

Salford Royal

Partners:

Salford Royal NHS Foundation Trust is an accredited hospital group leader. They have begun with a partnership with Pennine Acute Hospitals NHS Trust.

What are they doing?

The vanguard is designing a north west Manchester hospital group that will deliver outcome, quality, safety and efficiency benefits for members. The model involves: the development of an outcomes based organisation; the sharing of support services and back office functions; and technology driven health care. This work takes place against the backdrop of devolution in Manchester.

Business Model

The vanguard is exploring consolidated forms where a number of trusts work together under a single group structure. Whilst some members will join via collaborative or contractual agreements, other members may join through formal merger and acquisition. Each operates within an organisational structure where there is separation of strategic management, in a group headquarters, from operational management at each managed entity or business unit.

Patient population:

2 million.

Website:

www.srft.nhs.uk

Multi-service networks

Developing One NHS in Dorset

Partners:

Dorset County Hospital NHS Foundation Trust, Poole Hospital NHS Foundation Trust, and the Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust.

What are they doing?

The vanguard is striving to develop a sustainable model of care for in hospital and out-of-hospital that meets the needs of the local population 24/7. Dorset's care model involves the three trusts collaborating on ten workstreams to provide one acute network of: clinical services (women's health, paediatrics, cardiology, stroke, ophthalmology and non-surgical cancer services); clinical support (imaging and pathology); and business services (health informatics and business support services).

Business Model

As a whole, the vanguard sits within the Dorset STP. The partnership is using different forms of collaboration across its workstreams. For example, it is looking at setting up a One Dorset Pathology shared service via a contractual joint venture. In this model, one Trust would act as host on behalf of the shared service organisation, employing all staff and managing all contracts to provide one pathology service for the whole county.

Patient population:

766,000.

Website:

www.dorsetccg.nhs.uk/aboutus/vanguard.htm

Working Together Partnership

Partners:

Working Together Partnership is a collaborative partnership between seven acute trusts in South Yorkshire, Mid Yorkshire and North Derbyshire.

What are they doing?

Working Together Partnership is developing sustainable models of acute care for both smaller hospitals and multi-site trusts through a wider perspective on problems that cannot be solved or services optimised at single organisational level. The vanguard is running eight projects to support greater standardisation of processes, informatics and sustainable service configuration.

Business Model

Working Together Partnership is planning to use different partnership working arrangements for the different projects underway. As a collaboration as a whole, the vanguard has a joint working agreement and has formed a committee and common governance structure whereby each partnering organisation has set up its own committee, which has an identical membership and agendas between them. Each committee can only make a decision in relation to its own organisation but the decisions are co-ordinated.

Patient population:

2.3 million.

Website:

www.workingtogethernhs.co.uk

Single-service networks

The Cancer Vanguard

Partners:

The Cancer Vanguard is comprised of three healthcare systems: i) Greater Manchester, ii) West Essex, North Central and North East London, and iii) North West and South West London, led by The Christie, University College London Hospital (UCLH) and The Royal Marsden.

What are they doing?

The Cancer Vanguard is focused on accelerating the delivery of the National Cancer Strategy (July 2015) priorities. It aims to introduce accountability for the whole patient pathway to improve clinical outcomes, patient experience and health outcomes. Its care model is about prevention and early diagnosis, reducing variation across clinical pathways, as well as implementing collaborative governance and workforce models and information sharing systems to improve how organisations work together.

Business Model

The Cancer Vanguard is using alliance agreements to share accountability, targets and workforce across its partner organisations. The vanguard is also working with Cancer Alliances across the country to establish a community of practice forum in support of this.

Patient population:

Over 10 million.

Website:

<http://cancervanguard.nhs.uk/>

Cheshire and Merseyside Women's and Children's services

Partners:

Cheshire and Merseyside Women's and Children's Services is comprised of 27 organisations working together across commissioner and provider organisational boundaries. It aims to address the complex challenges faced by local services (e.g. greater service demand; increase in complex needs patients; variation in care quality) and to provide personalised services that better meet patient needs.

What are they doing?

Cheshire and Merseyside Women's and Children's Services is developing a safe, high quality, clinically and financially sustainable whole system model of care for local women's and children's services. The care model is about self care and prevention, using integrated team approaches to health care, and resolving pressure on the workforce through shared services.

Business Model

Cheshire and Merseyside Women's and Children's Services are using a Memorandum of Understanding (MoU) to underpin its partnership model. The MoU allows the vanguard to bring together its 27 partners including commissioners, providers and clinical networks, under a single governance framework. This aligns with the geography of their STP.

Patient population:

2.4 million (combined).

Website:

www.improvingme.org.uk/

EMRAD (East Midlands Radiology) consortium

Partners:

EMRAD is a consortium of eight East Midlands NHS trusts and foundation trusts.

What are they doing?

EMRAD aims to deliver expert and timely radiology care for patients within the East Midlands (10% of the UK population). The vanguard is focused on creating a high quality and resilient, fully accountable clinical network which is aided by a shared technical system. Once developed, this network will set a national standard for other NHS radiology services to follow.

Business Model

The vanguard is implementing a co-ordinating agreement that commits partners in the same way. EMRAD chose this model as all eight trusts can work together operationally whilst remaining separate as organisations. Partners have freedom over whether to be involved in the consortium and therefore those within the consortium remain active participants.

Patient population:

6.5 million (combined).

Website:

www.emrad.org/

MERIT (Mental Health Alliance for Excellence, Resilience, Innovation and Training)

Partners:

MERIT is an alliance of four NHS trusts in the West Midlands who provide specialist mental health services.

What are they doing?

MERIT's care model is focused on services provided to working age and older adults receiving specialist mental health services from the four trusts. The four partners will work together to solve efficiency, workforce, equality and policy implementation challenges. The four trusts are implementing a shared bed management system and interoperable patient records. They are sharing best practice and standardising practices such as admission, discharge, referral and transfer criteria.

Business Model

The vanguard implemented a Memorandum of Understanding (MoU) that commits the partners to working together whilst retaining individual sovereignty. This approach enables different organisations to build robust relationships that enable them to support and challenge each other.

Patient population:

3.4 million (combined).

Website:

www.wmmeritvanguard.nhs.uk/

Moorfields Eye Hospital NHS Foundation Trust (Moorfields)

Partners:

Moorfields Eye Hospital NHS Foundation Trust.

What are they doing?

Moorfields has developed a networked satellite model of care that has potential replicability across acute care. Moorfields' care model is about consolidating its learning in delivering networked care, so it and the wider NHS can have a clear understanding of when and how this model of care can enable acute hospitals to become clinically and financially sustainable.

Business Model

Moorfields Eye Hospital NHS Foundation Trust is a provider of eye health services, currently delivering services from 32 sites in the UK. For the vast majority of these services Moorfields has service level agreements in place. This means it owns the activity, employs the staff, buys and maintains the equipment and pays the host trust or landlord for the space. The only exception is Bedford where the host trust is directly commissioned to deliver the service and Moorfields is sub-contracted. Several of the early networked sites were initially on this sub-contracted basis but soon moved to the full ownership model.

Patient population:

N/A

Website:

www.networkedcaretoolkit.org.uk

The Neuro Network

Partners:

The Walton Centre NHS Foundation Trust is working with 20 organisations across commissioners, providers and the voluntary sector in Cheshire and Merseyside.

What are they doing?

The Neuro Network aims to develop a high quality and cost effective whole system neuroscience service. The programme builds on the partners' history of working together in networks to deliver neurology and spinal services in Cheshire and Merseyside. The vanguard's work will enable patients to have local rapid access to high quality neurology and spinal services from a regional specialist centre.

Business Model

The Neuro Network vanguard is moving towards formalising their membership model through an alliance agreement as relationships between partners develop.

Patient population:

3 million (combined).

Website:

www.thewaltoncentre.nhs.uk/443/the-neuro-network-vanguard--.html#

National Orthopaedic Alliance (NOA)

Partners:

Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust in Oswestry; Royal National Orthopaedic Hospital NHS Trust in Stanmore; Royal Orthopaedic Hospital NHS Foundation Trust in Birmingham, Oxford NHS Foundation Trust and Wrightington, Wigan and Leigh NHS Foundation Trust.

What are they doing?

NOA aims to create a UK-wide franchise or chain of orthopaedic providers to deliver outstanding and consistent care in more areas. NOA is using a membership and accreditation model, tools and quality standards that can be replicated by providers across other specialities to set standards of excellence and reduce variation in clinical practice.

Business Model

The vanguard has implemented a membership model where members pay to join the alliance and are able to access evidence based standards for orthopaedics. By being a part of the Alliance, members agreed to: adhere to a codified set of standards, protocols and processes; a set of benchmark targets all members must meet to retain membership; and a focus on continuous quality and safety improvement. There is potential for versions of this membership model to be applied to other speciality areas.

Patient population:

N/A

Website:

www.rnoh.nhs.uk/health-professionals/national-orthopaedic-alliance

Appendix B: Useful resources

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The following reports are available on request at england.newcaremodels@nhs.net

Mental Health Strategies MERIT Vanguard Evaluation report (2017)

Neuro Network Tranche 2 Independent Evaluation Report (2017)

Optimity Partners & Methods Advisory EMRAD Evaluation Report (2017)