

New care models:

Lessons learned so far and tips for moving forward





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Introduction

In producing *New care models: Governance between organisations* in 2015, NHS Providers and Hempsons sought to address the key challenges of delivering good governance between organisations which are working collaboratively together.

This year we have built upon that guidance in the light of significant developments in the sector over the last 12 months, not least the introduction of the Success Regime and of Sustainability and Transformation Plans (STPs) for local health economies. It has become clear, if it wasn't already, that working across local health economies to deliver services to the public more efficiently and effectively, is not an optional extra. Working as a health economy and collaborating across traditional boundaries will be part and parcel of delivering new care models. It is also likely to be a yardstick against which organisations are judged.

The emphasis on systems rather than organisations has led to an entirely proper focus on designing services around the patient. We should not forget, however, that systems do not exist in a vacuum. They exist in interactions between organisations and between individuals and organisations. Organisations are the bodies that can be held to account, not the system within which they operate. And if we are holding organisations to account, then we should be looking to ensure that they are well-led through strong

corporate governance. So in embracing the new system approach to working we should also ensure that we retain the best aspects of the current system.

Recognising the accountability of organisations within the current system means that we also need to look closely at the role of those organisations in making new care models a reality. That means considering how CCGs and local authorities commission new care models and how providers address organisational form. Key enablers to success such as workforce, estates, data sharing and IT integration must also not be forgotten.

This publication, jointly produced by Hempsons and NHS Providers, builds on the guidance and support we offered in 2015. It incorporates lessons learned from the developing new care models so far and gives tips to help other new care models move forward. We hope that it will prove to be just as helpful.

New care models and working as a system: the role of corporate governance

How do we work more effectively and efficiently as a system to deliver healthcare that is both affordable and meets the standards expected by the public? The constituent players in local health economies are being asked to come together to address that question. At the same time organisations are working together to transform the way in which care is delivered through new care models. Some health economies fall under the Success Regime which has a slightly different emphasis, but is still about system change over a locale. And of course provider organisations are being asked simultaneously to deliver efficiencies to tackle growing annual deficits.

There is a sense of urgency in these areas of work spurred by the knowledge that the current system is not sustainable in the medium term. While the evidence base that these initiatives will lead to the required outcomes is not substantial, a great deal has been invested in their success.

However, this imperative brings with it a number of substantial risks that we need to tackle even as organisations change.



Risks in new system working

Accountability

The history of corporate governance in the UK, starting with the Cadbury report in 1992, has been about ensuring that businesses are properly directed and controlled, not because the organisation has an unquestionable right to continue to exist, but to ensure that it is the owners that benefit from the endeavours of a business or organisation.

We, the public, are the moral owners of the organisations that make up the NHS. One of the more helpful elements of current NHS law requires the boards of foundation trusts to act with a view to promoting the success of the trusts so as to maximise the benefits (the provision of high quality healthcare) for the trusts' members and the public. In other words, the first duty of boards of directors isn't to the organisation itself, but to its members and the public, as the organisation's and the service's owners.

However, if the owner or user of the service is to hold it to account, then there needs to be something that exists in law to actually make it accountable. Systems and processes cannot be held to account, only individuals and bodies corporate. So there is a risk that the emphasis on systems working could weaken proper accountability. This certainly needs detailed thought as regulators like the CQC start to consider whole-system regulation.

Management priorities

A second facet of the history of corporate governance in the UK and abroad has been an understanding of the uncomfortable truth that over time managers tend to organise what they do, and by implication the way the business operates, for the convenience of managers rather than for the benefit of owners. Many managers are reluctant to hear this, but the evidence is there from the extreme cases such as Enron to the mundaneness of organisations with a culture that clearly is not about meeting the needs of the people they serve.

Recent history in the NHS suggests that it is not immune from this tendency. In the UK, governance through unitary boards has provided an effective means of ensuring that organisations remain focussed on the interests of their owners, the public in the case of the NHS.

Group-think

A third issue is that we know that groups of similar people are prone to group-think. This isn't just about similar people holding similar opinions, it is far more impactful. At its most extreme, it manifests itself as a collective intolerance of disagreement, self censorship and the development of a narrative about the organisation that does not resonate with outsiders. In such, groups failures are rationalised and those who dare to dissent are stereotyped as troublemakers.

One of the best bastions against group-think is diversity of background and experience coupled with the rigorous exercise of individual judgement, in other words, a strong cohort of engaged, but vigorously independent, non-executive directors.

And as we enter a period of quite turbulent change, new risks to the effective and safe delivery of services are likely to emerge, placing an increased emphasis on the need for effective risk management regimes. For robust risk management regimes to deliver, they need to be based on facilitating assurance, something that also relies on the input of non-executive directors.

So, if these things are correct, and the evidence is there to support that they are indeed true, then what needs to happen to ensure that health and care provision is accountable to those who use it and to those for whom it is provided? How do we ensure in the rush to 'get on with it', that there is effective oversight of the work of executive directors and that they are properly held to account for what they do? How do we defend against group-think and promote risk regimes that result in real assurance?



Good corporate governance

Systems and organisations: In our 2015 publication *New care models: Governance between organisations*, we assumed that there would be an automatic preference to deliver new care models through organisations working together as constituent parts of a larger system. Since that time the narrative within the NHS has moved on, with the emphasis on systems rather than on organisations.

The idea of designing a system of services around the needs of patients, rather than one based on traditional demarcations, is attractive and clearly organisations should not put their own self interest ahead of the needs of the people they serve. However, we have very quickly allowed the idea to develop that operating as a system and acting as an organisation are opponents in a zero sum game; that if you do one you cannot by definition do the other.

The basis for this lies in Section 152 of the Health and Social Care Act 2012, which introduces the duty of directors of foundation trusts to 'act with a view to promoting the success of the corporation so as to maximise the benefits for the members of the corporation as a whole and for the public.' This has been taken by some to mean that the success of the organisation should be paramount. But we believe this is a misconception and that directors have a direct duty to the public that matches or perhaps outweighs their duty to the organisation.

Clearly the interests of the organisation and the system in which they operate will not always be the same, but the overriding consideration for NHS directors should be where the interests of the public lie. This is entirely consistent with both system working and the on-going existence of organisations.



The benefits of bodies corporate: Nor should it be forgotten that NHS trusts and NHS foundation trusts exist as bodies corporate for good reason. Bodies corporate can be held to account and compelled to take or not take action. Unincorporated bodies are in essence nothing more than a number of individuals working together to take decisions. Dealing with them is well and good when all is plain sailing, but when problems occur as they inevitably will, unincorporated bodies can be very difficult to hold to account or indeed to direct at all.

So if we are to deal with the risk inherent in system working, we will continue to need bodies corporate. This means NHS trusts, NHS foundation trusts and joint venture companies set up by them will need to continue to be the backbone of the provider sector. It also suggests that the delivery of new care models will be best done through formal means: either through transactions or through robust contractual mechanisms. We look at the options in detail in Chapter 4 on organisational form.

Leadership and the integrity of the body corporate: The continued need for strong board leadership is likely to be paramount in delivering new care models, in delivering STPs and in ensuring that the two are aligned. Boards provide for the possibility of dynamic strategic leadership and while the strategies of individual organisations may be subsidiary to health economy-wide plans, they are still an integral part of delivering change.

Good health economy-wide strategies will be based on the principles of subsidiarity, with only those few decisions that need to be taken collectively taken at the economy-wide level with most decisions taken more locally. The strong non-executive presence on local unitary boards means that they can provide an effective means by which executives can be held to account, their work overseen and risks can be properly managed. Unitary boards are essential to setting and leading a positive local culture that is inclusive and can act as a safeguard against group-think.

If we really do wish to change how care is delivered, we need to ensure that we preserve the integrity of the body corporate coupled with sound leadership from unitary boards.

Formality: No less a requirement is the need for formality. If the system is to work together it needs to do so under formal agreement between parties in the form of contracts or by bringing the parties together into single entities via transactions. If new businesses are to be formed as joint venture companies, then their owners need to ensure that they have the means to control and direct what they do.

As we pointed out in our 2015 publication, joint ventures and even wholly owned subsidiaries may well diverge in their aims and strategies from those of their owners over time. So it is important to nurture a common culture that will allow for a shared understanding of what is required and how it should be delivered. But even then there is no substitute for a formal contract in ensuring that what is required is delivered and that there is proper means to recourse if it is not delivered.

As things stand, many new care models and examples of cross organisational working have grown organically, and often tough decisions about future governance and organisational form have been deferred with the service delivery being seen as paramount. While the prioritisation of service delivery is commendable, it should not be allowed to stand in the way of often tough decisions about how emerging new organisations and collaborations should be controlled and directed.

Relationships between partners may continue to be good over time, but they are invariably good at the outset and there is therefore never a better time to grapple with tough decisions about control and direction and to reach agreement. To wait may lead to deferring a decision until there is a pressing need, which is often when there is a problem or where there is a substantial disagreement that cannot easily be resolved within existing structures. It is unlikely that such circumstances will be more conducive to better decision making than those available at the outset.

Local accountability: A further consideration for those concerned in delivering new care models is the role of accountability relationships with local people. The foundation trust model formalises relationships between boards and the community via councils of governors. Some of the perhaps unrecognised benefits of the foundation trust model of accountability are the openness and transparency the relationship promotes.

Being actively accountable to communities is good for boards because it requires them to check again that their sources of assurance and that risk is being properly managed, are good enough and promote vigilance. It would be beneficial to examine how the model can be adapted in the development of new care models. How governors relate to companies part-owned by their organisation for example, needs careful consideration, but it is clearly possible to envisage a beneficial relationship.

So in summary, the successful implementation of working as a system will require the continued existence of the organisation. For foundation trusts that means that directors will need to focus their efforts on their duty to maximise healthcare benefits for the public, with their organisation being a component means to that end.

Strong leadership by unitary boards is essential, to deliver change within and across organisations, while managing risk and providing effective oversight of the work of executive directors. We also believe that strong boards are the best means of promoting open and engaging cultures that provide a solid defence against group-think.

Notwithstanding the temptation to avoid formality, formal arrangements, either through transactions or contracts, provide the best means of ensuring the proper direction and control of inter-organisational systems that go to the heart of good corporate governance. We urge early decisions on how new care models will be directed and controlled. Because to defer decisions is to invite possible problems. Finally, we encourage the continuation of sound local accountability relationships.



Commissioning a new care model

The first and most important step in the development of any new care model is clarity of purpose about the population health and care outcomes partners wish to achieve, and the preferred care model. Experience to date suggests that many local economies, whether vanguards or not, have made a lot of progress on this front.

So what happens once everyone has signed up to agreed outcomes and a care model? That is the stage at which partners need to work through the detail required to make the new care model happen.

For providers, that means looking at the organisational form, which we cover in the next chapter.

For commissioners – CCGs, NHS England and local authorities – that means considering the steps needed to commission the model. It is important to be aware that commissioners will remain accountable for commissioning the model, whatever new care model is being adopted.

“Engaging early has allowed us to consider our strategy in line with the relevant procurement law position, taking advantage of additional flexibilities that were available. We have been able to build relationships right from the beginning of the project to support our new care model proposal.”

**NHS Stockport CCG, participant in Stockport Together
Multispecialty Community Provider vanguard**

Key steps for commissioners will be:

Step 1: Being clear about the services to be included in the new care model, whether primary care, community, mental health, social care services or any combination of them. A lesson from recent projects is the need to consider the role that existing core primary care services will play in the new model

Step 2: Deciding whether the model will result in service changes, both in respect of the way services are delivered or the range of services available – if so, early consideration will need to be given to complying with statutory duties to involve service users and other stakeholders in the development and consideration of proposals for changes to services

Step 3: Mapping existing contracts against the contracting arrangements that will be needed to commission the new care model – where commissioners want to award a new contract, for example a long-term outcomes based contract, they may not be able to do so without terminating existing contracts which in some cases, may require the consent of providers

Step 4: Determining the form of any contract to be awarded and its key terms. The form of contract will depend on the services which are to be bundled in it and key terms will be duration and payment, in relation to which NHS contracting mechanisms offer increasing flexibility

Step 5: Deciding on a procurement strategy for any contracts to be awarded, including considering whether the award of contracts without running competitive tenders is compliant with procurement law – an early understanding of the market, the likely level of interest in the contract opportunity and commissioners' key drivers, will help shape decision making about the strategy.

Organisational form for a new care model

Organisational form is the way in which the various health and care bodies in a local economy organise themselves to deliver a new care model. This chapter looks at the options for this.

It is often said, that there can be too much focus on organisational form, and it is undoubtedly the case that the priority should be on identifying population health and care outcomes and the preferred care model. Focus on leadership and culture is also essential.

But organisational form cannot be ignored and, in fact, can be useful for helping partners to develop their thinking about how they can deliver the new care model.

Understandably, there is often a lot of staff and public loyalty to maintaining existing organisational forms. But success will require organisations to think beyond their statutory and organisational borders. Working in partnership across traditional boundaries will be essential to deliver new care models fit for the twenty first century.

There is no 'right answer' to the question of which organisational form best suits a particular model – the much-quoted 'form follows function' really is true here. All of the organisational forms described in this chapter can be established by one of three legal models:

- **Contractual joint venture** in which participating parties enter into one or more contracts with each other (for example lead/sub-contractor arrangements, alliance contracts or management contracts)
- **Corporate joint venture** in which participating parties create a new jointly-owned independent legal entity to carry out services on their behalf (for example GP federations and companies set up by foundation trusts and GPs)
- **Mergers or acquisitions** in which one party acquires the assets and liabilities of one or more other parties (for example GP super-practices and trust mergers).

Broadly speaking, contractual joint ventures involve less integration and are easier and quicker to deliver than corporate joint ventures and mergers, but corporate joint ventures and mergers allow for more formal consolidation and independent brand identity.

What is an Accountable Care Organisation in the NHS?

The concept of accountable care is relatively new to the NHS. A commonly held definition of accountable care is a model which brings together a variety of provider organisations to take responsibility for the cost and quality of care for a defined population within an agreed budget (for example a capitated budget).

An accountable care model can take many different organisational forms ranging from loose alliances or partnerships, in which organisations retain their own autonomy but agree to collaborate, to fully integrated networks of hospitals and other providers. Whether the model is called an Accountable Care Organisation, System or Partnership is likely to depend on the extent of organisational integration involved.

Many new care models are ambitious to become accountable care models. However, accountable care models are likely to be complex and time-consuming to establish given they will be dependent on the award of capitated budgets under long term contracts. On that basis, an accountable care model might be the end goal of a new care model rather than something that can be established

"First and foremost, the high level of trust between the partner organisations allowed us to develop a really strong vision for what we wanted to achieve. Our aim was to be ambitious by creating an Integrated Care Organisation that would integrate adult community, mental and acute health and social care services for the benefit of our population. Identifying a preferred organisational form – a prime contractor model – at a relatively early stage, meant that we were able to move forward into the detailed discussions necessary to make the ICO a reality. A rigorous project management process has also been essential to the success of the programme."

Salford Royal NHS Foundation Trust, participant in Salford Together Primary and Acute Care System Vanguard

Integrating primary care, community, mental health and hospital services

Many local economies are looking at primary and acute care systems (PACS) and multispecialty community provider (MCP) models. Both models may involve joining up primary care, community, mental health and hospital services and/or moving specialist care out of hospitals into the community and closer to patients.

Typically the organisations involved in these models are commissioners, GPs operating through federations or super-practices, trusts, social care providers, voluntary sector and independent sector providers. In many places, the key conversations about organisational form at provider level are taking place between GP and trust leaders.

Often the decisions to be made are about which organisation or organisations will hold the contracts awarded by commissioners for the new care model and the role all of the partners will play in the model.

Possible options for organisational form for an MCP or PACS

- GPs hold a contract as lead contractor and sub-contracts, possibly to trusts and other providers
- A trust holds a contract as lead contractor and also sub-contracts to GPs and other providers
- A new company owned by providers holds a contract as lead contractor and sub-contracts, possibly, to the providers
- An alliance contracting arrangement

The preferred organisational form will depend on the answer to a number of key questions such as:

- Is the care model intended to be GP-led?
- Which primary care services will it include?
- Which hospital and community services will the model include?
- How can trust management skills and resources best be deployed?
- Are there legal or contractual restrictions on the transfer of existing contracts into the new care model or on which organisation can hold a new contract?
- What are the pros and cons of more formal integration by setting up a new company or merger/acquisition over lead contractor or alliance contract arrangements?
- If a new company is set up who will own and control it and what will it do?
- What form of contract do commissioners want to award?
- How will commissioners be assured that the organisations they commissions can deliver?

How can GPs collaborate for a new care model?

The NHS Forward View and General Practice Forward View identify that working at scale and through larger organisational forms will unlock greater opportunities for practices. Primary care in its current form (typically small partnerships of up to six Partners) may become unsustainable. So how can GPs collaborate in larger organisational forms for new care models?

In many places, GPs are already collaborating through ‘federations’; companies set up by a number of practices to provide some core primary care services and bid for new services. But is this enough?

‘Super Partnerships’ are now emerging and evolving. These are mergers of primary care practices at a scale never seen before. Whilst it has not been uncommon for two or three practices to merge, mergers of five to 20 practices have begun to take place. More recently Our Health Partnership (OHP) in central Birmingham has been established by the merger of just under 50 Practices, heralding the creation of far bigger entities. These Super Partnerships may be well suited to being collaboration models through which GPs can operate in, for example, MCP and PACS models.

“Our pioneering project aims to integrate primary, secondary and community care in one organisation. We have achieved this by integrating three primary care practices with the trust, with the trust providing NHS primary care services as a sub-contractor to three GMS primary care practices across five sites in Wolverhampton. This project will bring 23,000 patients under the trust’s care and will see the GP Partners continue to provide the primary care services as employees of the trust. The project is all about clinicians across primary, secondary and community care moving to a systems mindset and thinking about the total care of a patient.

“This pilot is being driven by the GPs and senior clinicians at the trust who are working in the best interest of their patients. But we recognised that to make this happen, we needed to look at organisational form, and that meant integrating the practices with the trust so that we can remove some of the processes that cause delays when multiple organisations are involved and make the system work more efficiently. We will look to share our learning across the NHS locally and nationally.”

**The Royal Wolverhampton NHS Trust,
participant in pioneering vertical integration project**

Integrating health and social care

Some new care models will involve integration of health and social care services, in particular the enhanced health in care homes and MCP models but also the PACS model.

The 'section 75 partnership arrangement'¹ is a well understood and relatively straightforward organisational form by which NHS bodies and local authorities can integrate their functions, both at commissioning and provider levels.

Building on Better Care Fund initiatives NHS and local authority commissioners can put in place joint or lead commissioning arrangements and pooled funds to facilitate the integration of services. Commissioners may also choose to establish joint committees to manage the arrangements. And as providers, trusts and local authorities can agree to provide some of each others' services.

Some local economies and vanguards have developed models that allow trusts to take on significant social care business from local authorities, integrating this with the hospital and community services provided by those trusts.

For these integration arrangements, key decisions have to be made about:

- The continuing role of the local authority for the purpose of complying with its statutory duties under the Care Act 2014
- How the partners will address the statutory restrictions on a local authority's powers to delegate its functions to a trust
- How financial risk in social care services transferring to a trust will be addressed
- Whether the local authority's care home and domiciliary care contracts will transfer to the trust and if so how the trust will manage that supply chain
- The implications for the transfer of local authority staff to the trust in relation to their terms and conditions
- Access to local authority premises, IT systems and data by the trust

¹ Section 75 of the NHS Act 2006

Integrating hospital services across multiple organisations and sites

The new care model programme is prompting hospital providers to consider new ways of collaborating with each other. In some cases this is to address issues of economies of scale and in others to make sure that best management and clinical practice of high-performing trusts is shared with their peers.

There are broadly three approaches. At one end of the scale is a loose, informal coming together of organisations with little or no legally binding obligations. There may be good reason for this approach but it may be difficult to realise patient benefits through a model which at its heart relies on goodwill between the providers.

At the other end of the scale is a formal merger or acquisition process, the end result of which is organisational consolidation and the dissolution of one or more providers. This may well have advantages but these will need to be clearly articulated.

In between these two extremes is an approach whereby the organisations involved enter into some legally binding commitments to one another, for example in a 'buddying' or management contract, but ultimately without going so far as one or more of the providers being dissolved. This is the approach being adopted for many developing hospital chains and groups.

What is a hospital chain in the NHS?

Like Accountable Care Organisations, hospital chains are a model which other countries such as Germany and the US are familiar with and which have a track record of success.

The key feature of a hospital chain is centralised strategic leadership for a group of hospitals with each hospital operating with agreed decision-making responsibilities locally, standard operating procedures and centralised back office functions.

The unique features of the NHS mean that international hospital chain models will need adaption here, but there is no reason why they cannot be successfully implemented. Early consideration of developing chains in the NHS has highlighted that key issues to be addressed are:

- Differences between foundation trusts and NHS trusts in a chain
- Merger control under competition law
- Procurement law, especially for management contracts
- Regulation of the hospitals in the chain
- Governance and accountability

Workforce challenges and opportunities

It goes without saying that the success of new care models will depend on the NHS making best use of its biggest asset, its staff. But the challenge for organisations and their staff, to deliver high-quality integrated services to a patient population with increasingly complex care needs, is substantial.

Experience so far suggests that for a new care model to be effective organisations will need, as a priority, to embrace new cultures and ensure their workforce has the right skills, values and behaviours to work effectively.

There are unique issues for specific models/organisations but a number of issues are common to most models and should be considered early in organisational development plans, specifically:

- Developing an **integration plan** covering the organisations' vision, operation, policies and culture in which a cross-section of staff should be involved
- Developing a clear strategy for **collaborative/integrated** working including the benefit of standardising key policies and procedures
- Developing the **new leadership** (management team) structure and strategy
- Creating an **organisational development plan**, including divisional structures and staffing levels
- Identifying the **education, training needs and regulatory requirements** of the current and future workforce, which may include new allied health professional roles
- Recognising that **partnering arrangements** may require joint posts/secondment arrangements to allow for work to be done across different sectors
- Application of **TUPE** and associated information/consultation processes
- Undertaking **due diligence** to assess the **scope of any liabilities** related to staff transferring between organisations
- Considering potential **redundancies/restructuring** exercises and associated consultation processes
- **Pooling resources** and the anticipated benefits (i.e. shared back office functions)
- Developing measures to support **employee retention and development** and to enhance recruitment to the organisation.

Considerations for redesigning your staffing arrangements

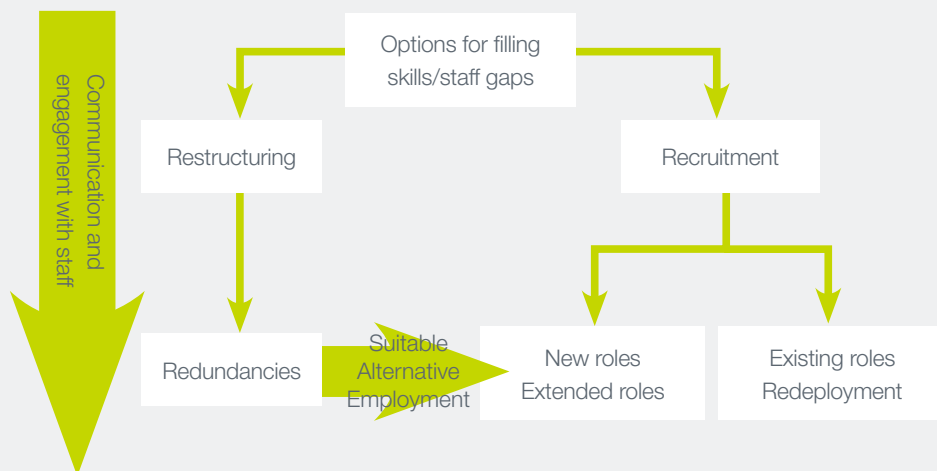
Key initial questions:

- What type of organisation are we?
- What is our culture and strategy?
- Have we got a strong leadership structure in place?
- What services are we going to be providing and where?
- What are our patients' needs?

The following questions then become relevant:

- What is our current staff mix – numbers, roles, skills, terms and conditions?
- What is the staff mix of our partner organisation – numbers, roles, skills, terms and conditions?
- Are there any staffing/skills gaps? How can they be filled? Does this create any educational/training/needs/issues?

Staff (re)design issues/solutions



Estates challenges and opportunities for new care models

Integrated new care models may create new opportunities to escape from the constraints of current service environments, but escape to where? Different new care models may imply different premises outcomes, for example:

- Expansion of primary and community services at a hospital site
- Expansion of out of hospital services in GP premises
- Expansion of primary care services in community and home settings

Equally, new care models present a tremendous opportunity to rationalise estate and create efficiencies – but only if achieving those estate efficiencies is an objective in itself, alongside patient-facing priorities.

When designing a new care model, organisations need to analyse where best to deliver the services from, which organisation will deliver those services and how they will own or occupy the relevant premises.

Decisions about the estate should be made early on and due diligence carried out. Key issues will be:

- Identifying the premises needed for the new care model
- Where premises are already in use, assessing the condition of the premises (are they fit for purpose?) and legal ability of the current owners to allow other organisations to buy or occupy them
- Plans of commissioners to ensure that key premises remain available for the wider service model if the existing owner is in performance breach or ceases to be part of the overall model
- Implications of rent reimbursement where primary care premises are involved
- Capital investment requirements
- For disposals, compliance with restrictions on disposals of NHS estate and EU State Aid restrictions.

Sharing data and integrating IT systems

The ability to share patient data quickly and easily between organisations and professionals is often cited as a key critical success factor for integrated care. But there is a perception that data protection rules make it difficult for organisations to share information and that integrating IT systems often presents insurmountable technical challenges.

But with a careful approach to information governance and a 'can do' attitude towards IT, there is no reason why these issues should get in the way of the success of a new care model.

The ideal solution is an integrated electronic patient record that combines all of the records created by each provider in the local health and care economy into a single source of information which is easily accessible by any clinician treating the patient.

Wherever partners are on the road to integrated electronic patient records, it is essential to make sure that information governance processes are in place to allow lawful sharing of data. It is important to note that sharing of patient data between organisations is possible provided the right processes are in place.

It may also mean finding a way of integrating information management and technology systems of different organisations.

These issues need to be addressed early in the process in order to find the right solution.

Tips for integrating IT systems

- Carry out due diligence to understand the nature of organisations' existing IT systems and the potential for them to successfully interoperate
 - Consider whether you have the right skills and resources available to deliver IT integration or if you need to access support from, for example, Commissioning Support Units (CSUs) and Academic Health Science Networks (AHSNs) or existing suppliers
 - Dialogue with existing suppliers should be initiated early to understand their approach to any changes to the nature or structuring of the systems, services and contracts already in place and any likely additional costs. Suppliers should also be able to add value by providing information on the compatibility of their systems with others and guidance on whether technical integration is feasible
 - If a decision is made to procure new IT systems or services, make sure you choose a supplier with the right attitude and flexibility of approach as well as the right technical solution, put in place a licensing model that allows all participants and relevant users to access and use the systems and build in flexibility to allow for changes in the future as the model develops.
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