APPENDIX C - OTHER MANAGEMENT OPTIONS CONSIDERED

1. Managed Clinical Networks

MCNs tend not to be hosted arrangements, being administratively based generally few people are employed in MCNs, rather they achieve results by enabling participants to come together to work through what needs to change. MCNs are regional bodies, which are in place to recommend and ensure that the highest quality clinical support is available to individuals in that region in respect of the services being provided. They do this by bringing together the various specialist health professionals involved in the care of people in the region to work collectively, between different hospitals and community services, and to drive forward improvements. Therefore, MCNs are a linked group of health professionals and organisations from primary, secondary and tertiary care, working in co-ordinated manner, unconstrained by existing professional and Health Board boundaries, to ensure equitable provision of high quality clinically effective service within a prescribed geographical area. The size, nature and coverage of each MCN is determined in consultation with stakeholders.

MCNs allow multi-disciplinary/multi-professional teams to work across traditional boundaries with the health service to deliver evidence based, patient focused services. Patient and public involvement is crucial to the MCN to help maintain this focus and provides vital feedback and advice about both current services and future developments. MCNs recognise the value of engaging with the public to identify what problems they commonly face and appreciate their contributions. The emphasis shifts from buildings and organisations towards services and patients. Its core members are the doctors, nurses and therapists delivering pathology services and other professionals can be co-opted as is appropriate.

In practice, MCNs are seen as permitting a variety of arrangements, where the exact nature of a network depends on its rationale and purpose. However, MCNs are fundamentally a means of enabling services to be formed, or linked, across organisational boundaries, where those boundaries would otherwise have restricted the coordination of resources.

1.2 Advantages

MCNs are a means of promoting a focus on patient access to and experience of care, identifying and sharing scarce existing resources and enabling the release of, or joint investments in, scarce or costly resources e.g. giving practitioners the opportunity to focus on a subspecialty, reducing barriers to the coordinated provision of services and providing a means of accounting for service performance across health care organisations. MCNs can help define the scope for services in a local area, identifying commissioning needs and population needs (current and future). They are effective at identifying best practice and identify gaps in existing service provision and key priorities for service improvement. MCNs often establish and share outcome measures/key performance indicators.

MCNs are recognised as promoting cost-effective services, improving patient experience and clinical outcomes, integrating care and promoting the equity of service provision.

They ensure collective capacity and the pooling of expertise and they have clear pathways for accessing specialist advice. They facilitate high quality training, promote quality improvement mechanisms and facilitate strategy development. MCNs can be effective in commissioning services that reflect the population need and in gathering and interpreting data to inform commissioning decisions.

MCNs can be effective in incorporating best practice from the expertise of network stakeholders; this encourages shared learning and the ability to resolve issues that may arise within the work of the network. MCNs can help to define priorities and reflect them into a detailed work plan that is reflective of national guidelines and local and service user priorities. MCNs can improve stakeholder relations, bridging the gap between providers and commissioners and provide a forum of support for healthcare professionals and commissioners.

MCNs can be particularly effective in reducing variability in health care provision; by understanding the local population need and gathering local intelligence from stakeholders, MCNs can tailor commissioning intentions to improve patient outcomes.

1.3 Disadvantages

The disadvantages of MCNs are that they may function on good will and collaborative working across organisational boundaries but without having dedicated funding, unless specifically set out in the annual funding allocation. Minimal historical contact between different specialties and disciplines may create barriers and difficulties in establishing an MCN. Responsibility sharing between individuals might be resisted, as it may be seen to undermine a clinician's capacity to treat patients or meet professional goals, consequently, it may be difficult to sell the benefits. Different individuals from different areas may have different ideas on how to bring about a good outcome and it may be challenging to get individuals to agree on what constitutes a good outcome. There may be increased costs and increased complexity in respect of the staff function, coordination and administration and legal fees

2. Memorandum of Understanding

2.1 A Memorandum of Understanding (MoU) can be used where public authorities wish to work together to develop and deliver a project jointly. It governs the relationship of the authorities and what roles and responsibilities they will undertake to deliver the project. MoUs set out key objectives for the collaboration, or where it is not possible to fully scope these objectives, the MoU will provide for a procedure to add new objectives. MoUs are also suitable for detailing the roles that two or more authorities may take in a joint procurement exercise, or in scoping and implementing a shared service project. MoUs can also be used for circumstances in which one party is delivering a service or carrying out a function (e.g. commissioning a service from a third party) on behalf of the other party(s). A specification for the services would accompany the MoU and would be developed defining the types and standards of services to be offered.

2.2 Advantages

MoUs are advantageous as they are widely adopted in the public sector, and SBUHB, HDUHB and PHW are likely to have templates available and will be familiar with their structure and content. Their familiarity tends to make them easier to negotiate and agree between the parties and finalise, thus saving time, resources and legal fees. MoUs are a convenient means of putting into practice less formal collaborations, whereby they can act as a management model and a contractual document to legally formalise the management model. MoUs set clear objectives and allow all parties to establish and clearly state their mutual intentions, objectives and goals. A MOU typically makes the objectives and expectations of all parties very clear, so the document helps prevent potential future disputes from occurring. If any party feels that their goals and objectives are not being met, they can easily end the agreement, as it is not generally legally binding.

2.3 Disadvantages

The disadvantages of MoUs are that whilst the parties will intend to honour their obligations under the MoU, they are generally non-binding in nature. As a contractual document, MoUs are not sophisticated enough to act as the operative document for a significant shared services relationship between two or more public bodies and for example, where TUPE is likely to apply

3. GROUP MODEL

3.1 A Group could refer to any organisational form that brings multiple provider organisations together to break down isolated departments or groups by working together in more formalised ways. A Group has an organisational model with a 'central HQ' function which is responsible for providing strategic leadership across the whole Group. Groups have discrete and locally managed 'operating units', which are likely to have their own management team, responsible for the operational leadership of that unit. Groups have standardised systems, practices, and protocols, which are implemented at each operating unit, thereby reducing duplication and waste, with a culture and values that are shared across the Group and which transcend individual relationships (although 'operating units' are likely to retain individual brands and identities relevant to their local population). A number of models and legal entities are able to meet this definition of a Group:

- Federation - several organisations come together to collaborate on areas of mutual interest and benefit. Each organisation retains its sovereignty and is therefore able to opt in or out of the federation. The agreement between organisations can be set out in a legal contract or in a Memorandum of Understanding.

- Delegated authority - several organisations agree to formally delegate some or all decision-making rights to a single organisation (for example, a Trust or Health Board). This single entity has authority to make strategic decisions on behalf of all members of the Group. Each organisation retains its sovereignty and the decision-making body will remain accountable to the Boards of each organisation. The Trusts/Health Boards will remain as individual legal entities, but could be supported by a joint venture between the participating providers.

- Management responsibility - one organisation takes management responsibility for another organisation, but each organisation retains its Board and could cover some or all management functions. The host organisation is accountable for its own performance and for the performance of those organisations under its management. The host organisation enters into a Management Contract to provide the management services for another organisation for an agreed duration.

- Wholly-owned subsidiaries - the Group is a single sovereign entity with discrete 'operating units'. The Group will have a single Board, accountable for the performance of all operating units and could be formed through the reorganisation of an existing organisation, or through a series of transactions.

3.2 Advantages of the Group structure – the organisations within the Group align strategically so that they are each working towards a common strategy and vision. Resources and expertise are shared across multiple organisations, resulting in joint learning by accessing a broader pool of knowledge and experiences. Within a Group structure the workforce is used flexibly between organisations, resulting in reduced agency spend and can lead to improved staff engagement through better career structures and investment in training and development. A group structure has the ability to make changes to services for the benefit of patients and to make decisions at pace. A consolidated number of back-office and clinical support services, supported by investment in systems and standardised processes can result in improvements in cost and quality through economies of scale and joint procurement. The cost and risk of investment is spread across multiple organisations.

3.3 The Disadvantages of the Group structure – delivering the benefits of scale will require investment to reconfigure services, develop new workforce models, develop standardised ways of working, and to invest in digital technologies; the benefits need to justify this investment. If Groups do not have the backing of the organisations within the Group, particularly the clinical body, they may struggle to implement new models of care. In some cases, the formation of a Group will result in the loss of some (if not all) organisational autonomy.

4. STRATEGIC CLINICAL NETWORKS (SCN)

4.1 SCNs are a whole system, integrated approach and operate as engines for change across complex systems of care, with the intention of maintaining and or improving quality and outcomes. They bring primary, secondary and tertiary care clinicians together with partners from social care the third sector and patients. The aim of SCNs is to help commissioners reduce unwarranted variation in services, address inequalities in health outcomes, encourage innovation, ensure best value for money and improve the quality of care and outcomes for patients. SCNs generally work on the guiding principle of engaging patients and the public in all their work, whether it is developing quality improvements or providing an oversight of the network's activities. Other organisations, particularly those from social care and the voluntary sector and private sector providers, will also be important partners in SCNs.

4.2 What distinguishes SCNs from other networks is the clinical leadership and the focus on clinical strategy. The term 'clinical network' doesn't reflect the fact that SCNs regularly work with a wide and diverse range of organisations and institutions beyond clinical, to be able to do their work. some SCNs cover multiple integrated care systems, each likely to have their own regional priorities and ambitions. Where these additional challenges exist SCNs may have to reconfigure their resources, or seek additional ones where required. However, the biggest challenge for an SCN is their lack of authority and power; SCNs remain (at present), advisory bodies.

43 SCNs are non-statutory bodies; they do not have a legal duty to commission health services. SCNs aim to achieve improved clinical outcomes through better commissioning and service provision. SCNs will have clear terms of reference and an annual accountability agreement with commissioners for the programmes of quality improvement they carry out, together with an annual work plan, informed by national improvement priorities. Generally, SCNs will have a Board and will appoint clinical and network directors, who are accountable to the local area team which hosts them.

4.4 The advantages of SCNs are that through their whole system approach, they have been shown to improve quality and reduce variation in services, facilitate the sharing of best practice, provide for cost-effectiveness, good accountability and governance and the sharing of expertise.

4.5 A disadvantage of SCNs are that they cannot be held directly to account for clinical improvements and outcomes.

5. OUTSOURCE TO AN INDEPENDENT PROVIDER

5.1 Outsourcing to an independent provider would mean that the pathology service would be fully managed and delivered by another organisation, for example, from the private sector or another NHS organisation. All assets, including staff and contracts would transfer to the outsourced provider and the Health Boards/PHW would only retain responsibility for management against the KPIs set out in the contract. There would be a single charge to the provider for the delivery of the service.

5.2 A full outsourcing contract must be put in place, which would cover all aspects of the service, including governance, equipment asset transfer, staff (transferred to the new provider under TUPE), logistics, access to facilities (e.g. laboratories), charges for services provided and any capital investment. The only control the Health Boards/PHW would have over the service is defined by the KPIs in the contract and the ability to re-tender at the end of the contract, or under any termination provision.

5.3 To award an outsourcing contract to the private sector, there will need to be a compliant procurement process to select a preferred provider of the service. The two Health Boards and PHW could jointly procure the Pathology Services. However, a procurement process may not be required if the contract is awarded to another NHS body and that award is outside the scope of the public procurement regime (the PCR 2015).

5.4 The advantages are that everything connected to the provision of the service, including management, accountability, scrutiny etc. come under one organisation. An outsourced provider is likely to have the technology and equipment to facilitate

innovation, improve quality and to make cost savings (although, this isn't always the case). Finally, any perceived flaws in the service can be deflected from the Health Boards and PHW to the outsourced provider, although, from a public perspective, that does depend on whether the public still regard the Health Boards and PHW as the 'provider' of the services, notwithstanding any outsourcing arrangement.

5.5 The disadvantages of outsourcing are that it may not align with the principles of collaborative arrangement, particularly if the contract is outsourced to the private sector. It could become more costly to provide services, depending on how the contract is set up and if there is a lack of effective contract management. There may be questions over transparency and the loss of training opportunities and whether one external provider could provide all the services and in a cohesive way – there is a risk that a private sector company may 'cherry pick' high volume, low complexity services. A private sector company may be driven more by profit than quality and may prioritise any other contracts over one with the Health Boards and PHW. Given that, for example, private hospitals largely rely on NHS Consultants carrying out additional work in their free time, the purchase of capacity from the private sector could worsen the availability of NHS staff in the public sector. There is a risk in respect of a breach of the data protection laws and the processing of sensitive personal data when such data is in the hands of an outsourced provider, particularly within the private sector. Finally, there may be a public perception, if outsourced to the private sector, that the NHS is being privatised by the 'back door'.

6. PRIVATE PARTNER JOINT VENTURE - SERVICES NOT DELIVERED BY A HEALTH BOARD/TRUST

6.1 An example under this joint venture model would be where two joint venture vehicles are established with the private sector, one for managing the delivery of pathology services and one for managing the pathology support services, including estates, equipment and IT etc. Both joint ventures then outsource service delivery to the private sector partner. The Health Board/Trust retain management control but benefit from the private sector's delivery expertise.

6.2 This arrangement is a partnership with an independent provider for the management of subcontracted pathology services, not for the provision of these services. These services are delivered by the private sector partner or another NHS organisation (e.g. an existing collaboration). To maximise VAT efficiency and comply with HM Revenue & Customs rules, two separate legal entities are generally formed as joint ventures. The selection of a private sector partner and supplier will require a procurement process compliant with the Public Contracts Regulations 2015 and internal Financial Standing Instructions.

6.3 Both joint venture companies would be responsible for the management of their own subcontracts with the pathology service providers. These joint ventures also provide strategic direction to the partnership and would allow for new NHS partners to join. They do not make a profit (or loss) from the services provided to the founding partners (i.e. HDUHB, SBUHB and PHW). The joint ventures transfer all risks and liabilities to the independent provider providing the services. The company set up to manage the contract for the delivery of the pathology services subcontracts delivery

of these services to the independent provider and all staff from the existing pathology services transfer into the company under TUPE.

6.4 Examples: Health Services Laboratories (a pathology joint venture between The Doctors Laboratory (TDL), University College London Hospitals NHS Foundation Trust and the Royal Free London NHS Foundation Trust) and Pathology First Analytics/Facilities LLPs (two joint ventures set up by Southend University Hospital NHS Foundation Trust, Basildon and Thurrock University Hospitals NHS Foundation Trust and iPP Analytics and iPP Facilities respectively).

6.5 The advantages are the separate identity and brand (where there is a private sector partner), it can be easier for other parties to join in, profit sharing is possible and they have a clear governance framework.

6.6 The disadvantages are that joint ventures can be complex and expensive to establish, they are subject to Companies House reporting requirements and tax liabilities may be incurred.

7. PRIVATE PARTNER JOINT VENTURE - SERVICES DELIVERED BY A HEALTH BOARD/TRUST

7.1 An example under this joint venture model would be where two joint venture vehicles are established with the private sector as in paragraph 4.1 above. Under this model, the Health Boards/Trust retain control of the delivery of the services, while gaining access to expertise from the private sector, however, the services continue to be delivered by the Health Boards/Trust. This is a partnership with an independent provider for the management and delivery of pathology services.

7.2 Separate companies are formed as a joint venture and are jointly owned by the Health Boards/Trust and the independent provider. This approach maximises VAT efficiency. each of the formed companies employ staff and are responsible for both the management and delivery of the pathology services. They will make a profit or loss and generally, all risks and liabilities remain with the owners of the joint ventures. Staff from the existing pathology services transfer into the company set up to manage and deliver the pathology services under TUPE.

7.3 The company set up to manage the pathology support services does not provide its service to the other company, but directly to the Health Boards/Trust. This maximises VAT efficiency. The selection of a private sector partner will require a procurement process compliant with the Public Contracts Regulations 2015 and internal Financial Standing Instructions.

7.4 Examples: Viapath (joint venture between Guy's and St Thomas' Hospitals NHS Foundation Trust, King's College Hospital NHS Foundation Trust and Serco) and The Christie Pathology Partnership LLP (joint venture between Christie Hospital NHS Foundation Trust and Synlab).

7.5 The advantages and disadvantages of this model are broadly similar to those set out in paragraph 4.5 and 4.6 above.

8. NHS PARTNERSHIP

8.1 In this model multiple NHS organisations would form a partnership to consolidate pathology services (in this case, SBUHB, HDUHB and PHW). No separate company is created. Under this model SBUHB, as the host, would incur all costs and receive income for the services from HDUHB and PHW. All staff from the Health Boards and Trusts' existing pathology services would transfer into SBUHB under TUPE. Existing client contracts, equipment contracts, facilities, etc. remain with HDUHB and PHW and are recharged at cost to SBUHB as the host. Over time the host is likely to replace these contracts with a central contract for both Health Boards and PHW, to benefit from the economies of scale of joint procurement. As such, all costs for the delivery of the pathology service sit with the host. This cost is then charged back to HDUHB and PHW according to the partnership stakes. If the host pathology service makes a profit (or loss) through this process, this is split between SBUHB, HDUHB and PHW according to the partnership stakes.

8.2 The advantages of this model are that it is generally attractive to staff and as such, they can achieve high levels of staff engagement, which in turn has been linked to better patient care and outcomes. They encourage the sharing of best practice and adopt the latest innovations wherever possible. The services are kept within the public sector and it is a familiar model for those participating.

8.3 Disadvantages of this model - the host delivers pathology services to the other Health Boards/Trusts under an Agreement. Under this model, the Health Boards/Trusts are both customers and owners, which can create conflicts – for example, when seeking to minimise the cost they are charged as well as maximise the profit of the joint venture. The commercial and governance can be complicated and there may be limited savings.

Examples - the Pathology Partnership (TPP) in the East of England and North-west London Pathology.

9. CAPITAL INVESTMENT JOINT VENTURE

9.1 The capital investment joint venture model is a variation of the NHS partnership model. However, it enables access to the private sector for capital investment and support service provision expertise. Under this model, all staff from the Health Boards/Trusts' existing pathology services transfer into the host (SBUHB in this case) under TUPE. Existing client contracts, equipment contracts, facilities, etc. remain with HDUHB and PHW and are recharged at cost to the host. As such all costs for the delivery of the pathology service sit with the host and are then charged back to HDUHB and PHW according to a pre-agreed formula. If the host pathology service makes a profit (or loss) through this process, this is split between SBUHB, HDUHB and PHW according to the ownership shares. The host delivers pathology services to HDUHB and PHW under an SLA contract.

9.2 Alongside this, the joint venture sets up a separate company, co-owned by SBUHB, HDUHB and PHW and an independent provider, for the provision of support services, for example, new equipment contracts, logistics, laboratory information management system and facilities. The company will control and manage these services and

contract out their delivery to the independent provider. This model gives access to capital as the company will incur capital costs for new estates and similar projects and will recharge these to SBUHB, HDUHB and PHW on an annual basis.

9.3 The advantages of this model are the sharing of risks and costs (and any profit), access to new revenue sources and technical knowledge and expertise.

9.4 The disadvantages are that under this model, SBUHB, HDUHB and PHW are both customers and owners, which can create conflicts.