Department of Health

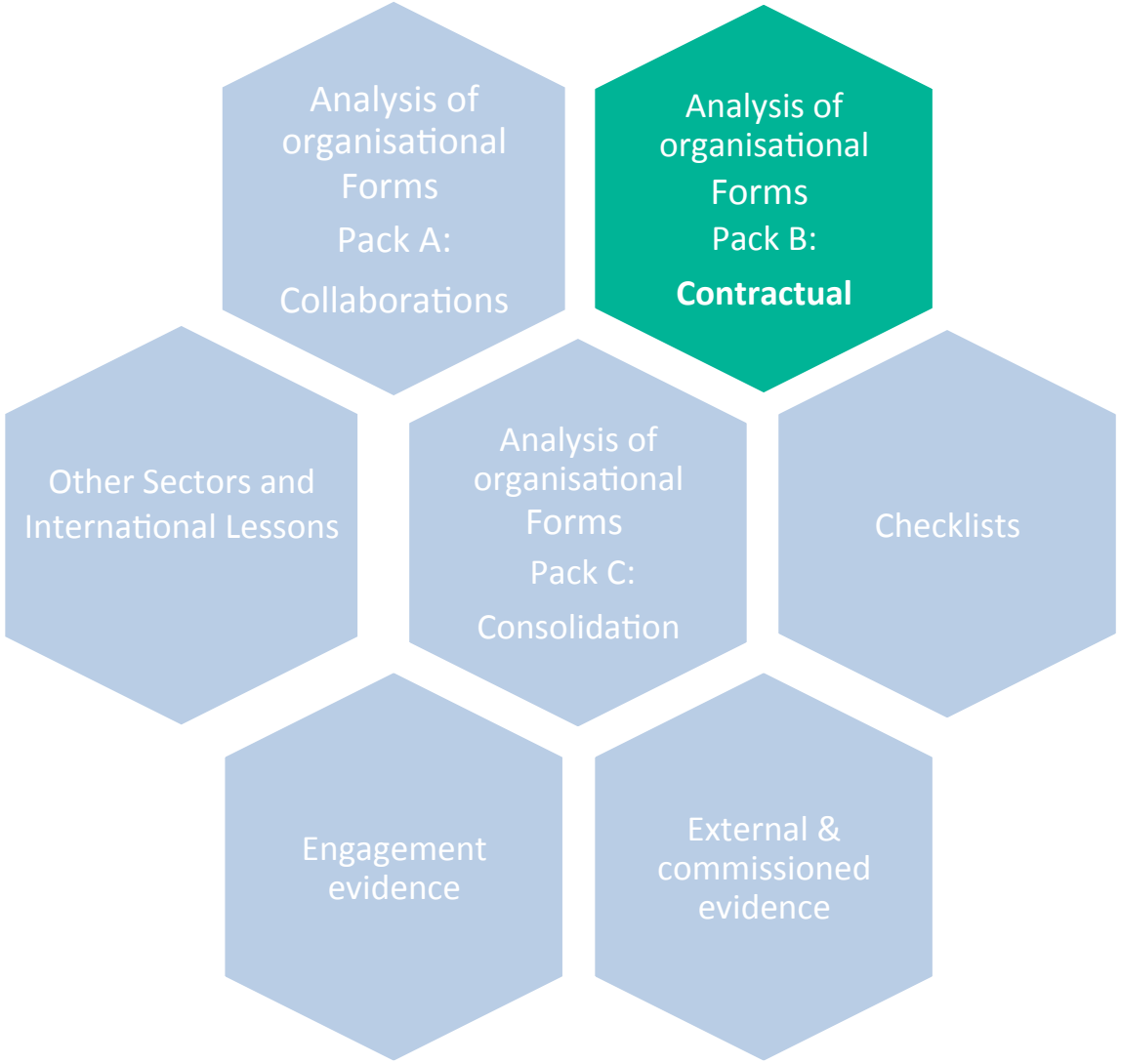
Dalton Review: Examining new options and opportunities for providers of NHS care

Pack B: Contractual Forms

December 2014

Contents

The key below outlines the supporting evidence to the Dalton Review: each pack is self-contained and can be read as a stand-alone document. This blend of evidence gathering, commissioned research and engagement feedback supports the recommendations of the Review.



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Pack B: Contractual Forms

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Overview

Overview

Enabling providers to actively pursue and develop new forms of organisational form can provide better care more efficiently

Organising and delivering care differently may raise standards and help reduce variation in performance

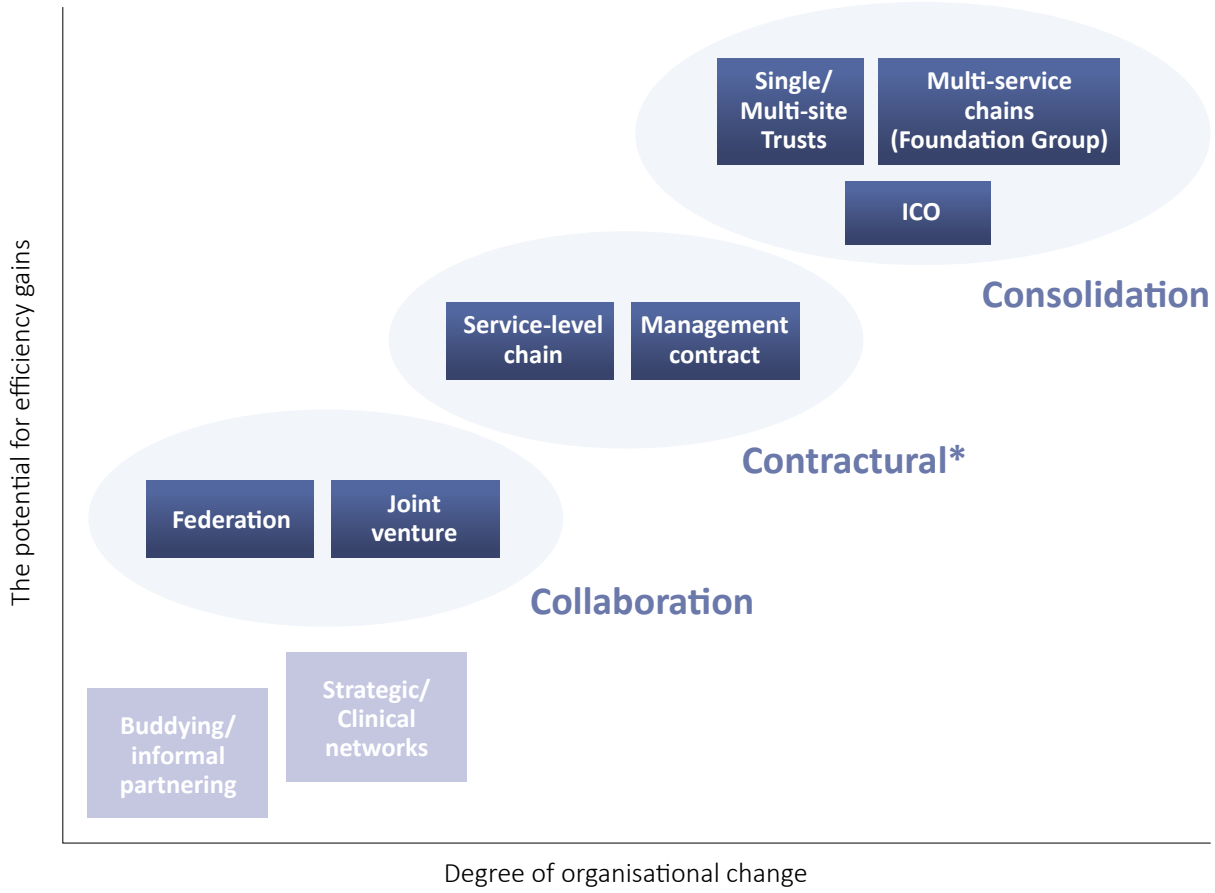
- Variations in performance among providers are wide and persistent, with some organisations having a long history of financial and clinical challenges.
- In a context in which there are increasing concerns about the quality of care providers deliver, looking for ways to organise and deliver services differently to raise standards across the board is critical.
- There is growing consensus in the sector that providers need to adapt and design better service delivery models in the interests of patients.
- New forms of organising care are likely to require providers to work together to combine skills and capabilities. Greater collaboration, cooperation and where necessary consolidation between providers will often be part of the solution.
- There is an expectation that different organisation forms will lead to greater market influence, increased economies of scale and scope, reduction in duplication of resources and improved efficiency in the provision of services. These and other motivations suggest that there are significant benefits to be derived.
- There are a wide array of options available to providers that should be explored to meet current strategic challenges. There is clearly a considerable learning to be shared from existing innovative practices which are not being spread more widely in the NHS.
- There is no universally optimal form that should be pursued in all circumstances. Creating a permissive environment, removing barriers and enabling organisational change is in the interest of patients and the health service more widely.

The evidence suggests that organisational forms could help drive improvements in the quality of NHS services

- An organisational form/structure defines an organisation through its framework, including lines of authority, processes and systems and resource allocation.
- Organisational change is about adapting to the present and shaping for the future, faster and better than the competition. The ability of an organisation to align, renew and grow, and sustain exceptional performance over time is key to organisation success.
- Changing organisational form can be hard; often needing to shift mind sets requires changing formal systems, structures, processes and incentives.
- It remains challenging to draw systematic comparisons of different organisational forms and the overall existing empirical evidence of the performance of types of healthcare providers is not clear-cut.
- Our evidence suggests that most of the organisational forms reviewed, from collaborative partnerships, to more cooperative arrangements and consolidation could help drive improvements in the quality of NHS services.
- The higher the degree of organisational change, the greater the potential for efficiency gains but also the higher the risk of the benefits being fully realised.
- Common success factors across all the different organisational forms include: strong leadership and good working relationships; a strong and shared focus on quality improvement that can be measured; and a focus on changing organisational culture.

Overview

There are three broad relationship types related to organisational forms – the higher the degree of organisational change, the greater the potential for efficiency gains in organisational forms



- Organisations may **collaborate** without any significant organisation change or cede organisational control such as buddying or clinical networks, as well as more formal collaborations such as federations and Joint ventures.
- At the next level, an organisation may form **contractual** arrangements to share control over one or more elements of its service portfolio, a service level contract or to day-to-day managerial control over an organisation through management contracts and operational franchise.
- Through to an organisation ceding full control, or gaining full control through the **consolidation** of a merger or acquisition.

Adapted from: Pearson, Jonathan (2011), "Options for healthcare group working", GE Healthcare Finnamore, Available at: http://www.gehealthcarefinnamore.com/insights/10-thought-leadership/13-options-for-healthcare-group-working.html [accessed 8/7/2014]

* Details contained in this pack

Overview

Key considerations addressed in this pack

What are the scenarios in which the form could apply?

Does the form apply across some or all geographical circumstances?

Does the form apply across different health economies?

To what extent does financial and clinical performance determine whether the form is suitable?

What is the role of organisational leadership in the form?

Does the organisational form interact with other organisational forms or is it a stand-alone form?

Does the form pass the three sense checks:

1. Does it make sense in the context described?
2. Will it make a difference?
3. Is it feasible?

Are the motivations to develop the form primarily defensive or strategic?

Are the barriers to the form primarily technical, strategic or a mix of both?

What support and incentives might be helpful to further the spread of the form?

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Literature Review – overview

Contractual relationships allows organisations to pool resources for a greater degree of risk sharing

The evidence suggests there are potential benefits in terms of gaining access to additional resources and widening the economic scope of services. However, the evidence highlights that effective contractual partnerships are dependent on the cultural fit and the quality of the working relationships between the organisations involved.

Service-level contracts

- Service-level contracts include service-level chains where individual services/service-lines are delivered either in freestanding satellites owned by the service provider, or in another organisation as part of their service provision.
- This includes subcontracting, outsourcing and near-shoring.
- A good example would be the form developed by Moorfields Eye Hospital NHS FT, under which they offer a range of specialist and routine ophthalmology services through satellite clinics in hospitals across London and elsewhere.

Management contracts

- Management contracts and operational franchises delegate responsibility for running the organisation (wholly or in part) to another organisation, for an agreed period of time. There is no asset transfer, the managed organisation retains control and ownership of assets.
- Management contracts aim to address leadership deficits in a Trust through the introduction of a new executive management team.
- The NHS has relatively limited experience of both management and operational franchises. Currently there is only one management contract operational in the NHS – Circle in Hinchingbrooke Health Care NHS Trust.

Literature Review – overview

Contractual partnerships already exist in the NHS – for contractual partnerships to succeed, clear governance and lines of accountability need to be in place

Service-level contract	• **Limited evidence:** There is limited literature "on the impact contracting has had on access, equity, quality, and efficiency of health care services delivery" (Liu et al, 2004). • **General costs and benefits are varied**. In general, outsourcing to specialised firms can enable lower production costs, as diseconomies of scope are reduced. However, "outsourcing imposes costs due to search frictions and imperfect contracting" (Grossman and Helpman, 2001). • **Outsourcing in knowledge-based industries, such as healthcare, helps attain intellectual value but this is difficult to measure**. Outsourcing in knowledge-based industries can bring "higher value, more flexible, and more integrated services than internal sources can offer" as well as enabling the outsourcer to concentrate on their own core competencies . However, it can be difficult to measure the benefits from outsourcing making it difficult to negotiate mutually beneficial contracts (Quinn, 1999). • **There may be concerns about losing valuable skills and long-term sustainability**. When contracting services out, some control over timing and quality of outputs are lost, and termination of services can be initiated by the service provider rather than the client. Additionally, outsourcing may lead to losing the internal skills in delivering certain services, making it difficult to balance short-term cost with long-term value-added goals (Quinn, 1999). • **Contract design is crucial to ensure an efficient outcome**. The service provider and the outsourcer have diverse interests and asymmetry of information, thus the contract needs to details the level of risk sharing and remuneration to ensure adequate delivery of services (Mills and Broomberg, 1998:8-9).
Management contract	• **A highly flexible form** that can be used to share best practice and improve performance of a less successful healthcare provider, and can be used as part of other organisational forms such as federations (Pearson, 2011). • **Where private organisations act as contractors in a NHS Trust, there is the danger that NHS risks are not understood and the local knowledge is not utilised to full extent**. As the contractor is an outside organisation the ability of the Trust Board to influence hospital activities is reduced. If the franchiser/contract operator is from the private sector they may not understand NHS policies and risks well enough (Pearson 2011). • **Tension can form between the contractor and managed organisation, particularly in healthcare setting**. The contractor business forms are often based on standardisation, whereas the managed organisation may seek to retain its identity "in the sense of a community service" (Malby et al 2014). The theory of contracting is part of broader economic theory concerned with the agency relationship (MacDonald 1984, Ryan 1992, Guesneri 1989, Lazear 1989, Ledyard 1989, Stiglitz 1989).

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Summary of contractual forms

We have found that examples of most of the organisational forms already exist in the NHS, while multi-service chains and ICOs are common in other health systems

The logos above represent many of the organisations visited or considered by the Dalton Review team. This does not indicate endorsement by the Dalton Review.

Summary of contractual forms – overview

There seven forms described in these evidence packs which are applicable in different contexts and in different types of health economy

Form	Potentially applicable to…
Federation	All geographies and most Local Health Economies (LHE) circumstances for sharing back office functions and performance improvement activities, significant sharing of clinical resources more likely to be limited to regional and contiguous. Unlikely to be a suitable response to serious financial difficulties.
Joint venture	Densely populated areas where, subject to demonstrating patient benefit from increased scale and focus of JV, activity can be consolidated without significantly impairing patient access to services.
Service-level chain	**All geographical and LHE circumstances. Dependent on the organisation's ability to replicate operational practices/ standards on new sites and having necessary capability and capacity to run services on distant sites. May be better suited to specialties or services that are relatively self-contained; where patients are likely to cross service boundaries between host and outreach organisations there are significantly greater challenges with clinical governance and accountability.**
Management contract	**Suitable for situations where poor clinical and/or financial performance can be transformed through change of control of some or all of the organisation's assets. These are time-bound arrangements with control being temporarily transferred to another organisation with sufficient management expertise and possibly some economies of scale. Not suitable where organisations are fundamentally unsustainable without major service reconfiguration in LHE.**
Multi-site Trust	Currently exists in all geographical and LHE circumstances, though may not be clinically and financially sustainable in some areas without significant service change and/or diversification. Expansion largely relies on ability to consolidate services, having demonstrated patient benefits, may be better suited to urban and suburban areas.
Multi-service chain (Foundation Group)	All geographical and LHE circumstances including non-contiguous configurations. Dependent on the ability of the Foundation Group to replicate operational practices/standards on new sites and having necessary capability and capacity to run services on distant sites. May be better suited than multi-site trust to acquiring new sites with limited potential for service rationalisation, probably less suitable for acquiring sites with significant financial problems and/or where LHE faces fundamental problems.
ICO	LHEs with a relatively large and well defined group of high-intensity service users have most potential benefits. Significant diversity of provider configurations, types of provider, contracting mechanisms and populations served means potentially applicable in any geography or LHE with sufficient potential to improve value for patients. Unlikely to be suitable response to short to medium-term financial issues given longer period to realise return as "integration costs before it pays" (Leutz,1999)

Summary of contractual forms – overview

Each of the organisational forms offer a different set of potential benefits…

Form	Potentially benefits
Federation	Sharing of best practice and alignment of patient pathways to improve outcomes and operational efficiency. Potential to share clinical resource and expertise and some back office functions to realise economies of scale.
Joint venture	Focus on managed services may lead to improved outcomes and operational efficiency. Access to skills and expertise of partner organisations and ability to separate risks borne by joint venture from partner organisations. Able to reinvest surplus directly into new equipment, upgrades and innovation if a separate corporate identity, giving staff greater feel of ownership over quality/ cost improvement. Could be used to create a hub for developing specialist expertise that could give rise to a service-level chain. May help partner organisations to meet the quality standards over seven days through the pooling of the clinical workforce.
Service-level chain	**Local access to expert specialist provision, ability for host provider to realise economies of scope through focus on core services, association with a specialist brand and income from outreach organisation. Outreach organisation spreads own brand, income creation opportunities, potential economies of scale and scope. May improve quality through the standardisation of clinical practices, protocols and procedures.**
Management contract	**Asset light way to allow alternative providers to deliver services to a population. Access to previously unavailable expertise providing financial control, standardised processes, some consolidation of non clinical functions. May address capacity or capability issues to allow focus on core site functions, or offer method of expansion through partnership with property or operating company.**
Multi-site Trust	Possible economies of scale through service rationalisation and unified and support functions. Ability to move staff between sites to meet changing demand and share expertise.
Multi-service chain (Foundation Group)	Improved quality and operational efficiency in new sites by standardisation and replication of proven operating frameworks, procedures and policies developed on existing sites. New sites benefit from strategic leadership, higher standards and support structures offered by the Foundation Group and may realise economies of scope through greater focus on operational management. May be possible for Foundation Groups to operate in situations that would be unsustainable for some standalone providers.
ICO	International examples have demonstrated improved patient outcomes and cost savings. Incentives such that care provided in most appropriate setting, focus on prevention and maintaining health, aligned patient flows.

Summary of contractual forms – overview

…and achieving those benefits comes with a different set of barriers and challenges for each organisational form

Form	Potentially barriers
Federation	Maintenance of organisational sovereignty may require reliance on consensus decision making, so significant strategic change may be difficult. Perceptions of competition regime may discourage cooperation, though competition only likely to be an issue in federations that are driving anti-competitive behaviour that has weak benefits for patients.
Joint venture	Lack of expertise in NHS bodies in contractual negotiations so may require expensive external advice. Regulatory and approval mechanisms for JVs commonly perceived as barriers, but Monitor do not need to approve less than 25% of change in income. Where consolidation results in reduction in competition there is a need to demonstrate requisite patient benefit.
Service-level chain	**Geographical distances can make quality and performance management more difficult as smaller scale means decentralised management structure less viable. Transition from single site centre to a hub and spoke form can be complex. Potential brand reputation damage if associated with bad practices at host or by outreach organisations.**
Management contract	**Difficult to establish and maintain appropriate governance and accountability. Where there are wider issues meaning the site will never be financially viable in its current form, the contractual constraints will not allow for significant enough change to alter this.**
Multi-site Trust	Normal barriers to acquisition and accompanying service change, i.e. consumes significant management energy, so the Foundation Group needs to have sufficient leadership headroom to devote to integrating the acquired sites as well as being able to maintain its own performance. Change of ownership may fall with in competition regime, not as restrictive as perceived but need robust demonstration of patient benefits.
Multi-service chain (Foundation Group)	Normal barriers to acquisition, i.e. consumes significant management energy, so the Foundation Group needs to have sufficient leadership headroom to devote to integrating the acquired sites as well as being able to maintain its own performance. Plus need to replicate the operating framework, procedures and protocols on other sites and be able to undertake the cultural change required to integrate new acquisitions. Geographical distance means effective decentralised management structure required.
ICO	Integration is not a quick way to save costs and should primarily be a way to improve outcomes and patient experience. In the short term integration usually requires investment and may see ROI only in the longer term and length of contract duration needs to be longer than the current three years for this to be worthwhile. Accurate data on patient flows, pricing and outcomes is required and is difficult to align IT and information systems to gather this reliably. Action and agreement on the commissioner side is also required to enable these forms to emerge more widely and effectively.

Summary of contractual forms – overview

There are also differences between how the forms are registered and inspected by CQC…

	CQC registration held by	CQC inspection of
Federation	If it creates a new legal entity, this must register in own right. If not, included in existing registration of each organisation in the federation.	Locations specified in the new or existing providers' registration.
Joint venture	If it creates a new legal entity, this must register in own right. If "pooled sovereignty", included in providers' existing registration.	Locations specified in the new or existing providers' registrations.
Service-level chain	**Provider (e.g. Moorfields).**	**Provider main location(s) plus service lines in the chain normally inspected separately, timed to coincide with inspection of their 'hosts'.**
Management contract	**Provider – the legal entity responsible for the service (e.g. Hinchingbrooke, rather than their management contractor).**	**Locations specified in the provider's registration.**
Multi-site Trust	Acquirer, or a new organisation created by merger.	Locations specified in the provider's registration.
Multi-service chain (Foundation Group)	Provider (e.g. BMI or Care UK).	Locations specified in the provider's registration.
ICO	Provider (however configured).	Locations specified in the provider's registration.

Overview

The application of competition law may also vary between organisational forms, but depends on changes in control

Archetype	Competition Considerations
Federation	The key question is whether the transaction gives rise to a change of control over the activities of a business. Transactions or agreements which would result in a change of control over all or part of a provider's activities (employees, assets or rights and liabilities), and which are above certain thresholds, may be subject to merger review. A merger can mean an acquisition, joint venture, transfers of service, asset swap or a management agreement between two separate providers. Mergers are only likely to raise competition concerns if patients and/or commissioners see the merging providers as important alternatives to each other (for example, because they are located close to each other or provide similar services) and there are few, if any, other providers patients could use. In relation to anticompetitive behaviour, Monitor's licence prohibits agreements that could have the effect of preventing, restricting or distorting competition but only to extent that they are against the interests of patients. For example, providers could decide amongst themselves which services they will stop providing to a commissioner. This sort of agreement could be to the detriment of the commissioner and the patients they represent. However, where agreements are in the interests of patients then these would be allowed even if anticompetitive.
Joint venture	
Service-level chain	
Management contract	
Multi-site Trust	
Multi-service chain (Foundation Group)	
Integrated Care Organisation (ICO)	Vertical integration is less of an issue than if two competitors merge as there is no duplication of services. There may be issues in relation to a gatekeeper role (i.e. could refer to themselves) which would be considered under the provider licence.

Useful guidance – Monitor and CMA short guide for managers
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/339830/CMA-MonitorShortMergerGuide-1.pdf
CMA guidance for organisations starting or going through the process https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/339767/Healthcare_Long_Guidance.pdf

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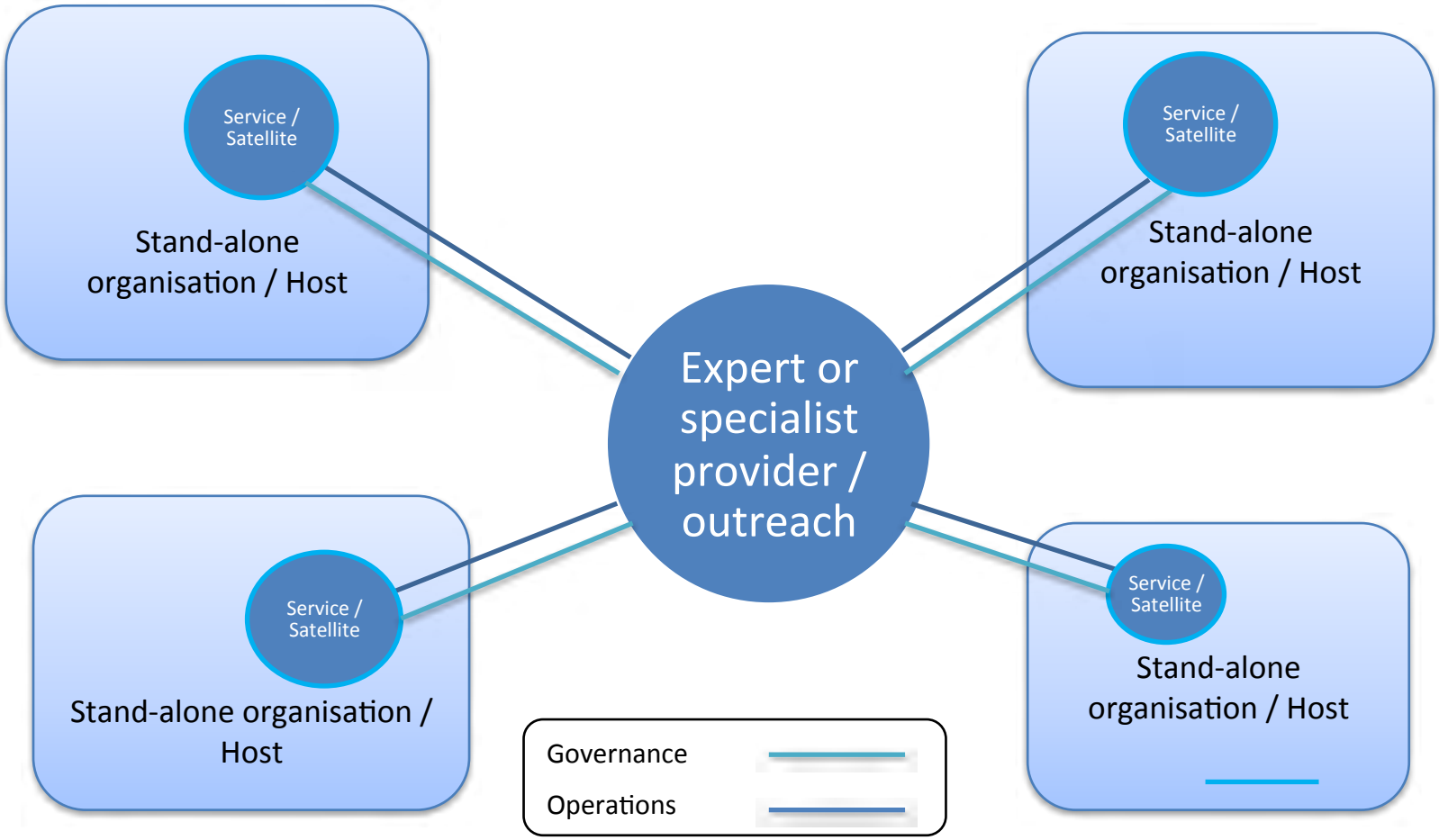
Service-level chains

What is the form?

Service-level chains are individual services (satellite) within a stand-alone organisation (host) delivered by an external specialist organisation (outreach)



What is the form?

Service-level chains are varying in nature – with different governance, operations, financing and asset sharing arrangements

Organisational sovereignty	Assets	Intangibles	Range of services	Scale
Both host and outreach organisations maintain sovereignty and jointly agree key issues.	May share assets (equipment and premises) but rarely staff. Sharing dependent on arrangement.	Outreach organisations usually bring a set of consistent intangible assets – e.g. clinical pathways, human capital, standardised procedures.	Typically one specialism.	Usually local or regional level.

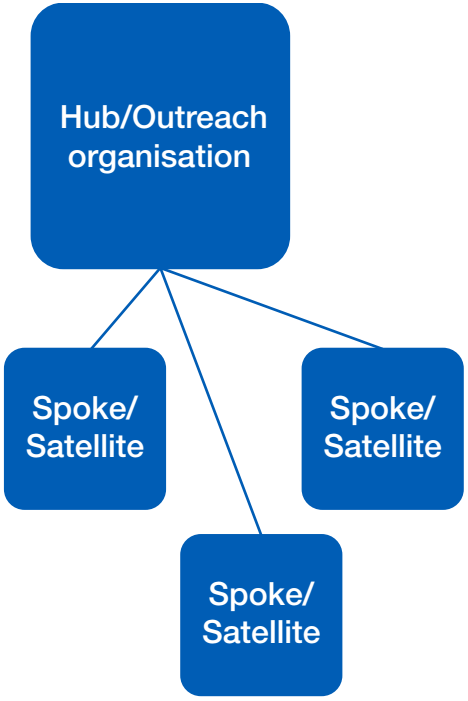
Key features:

- Expert or a specialist provider (outreach organisation) delivering services, typically for another organisation (host organisation), typically at the host organisation location.
- Can also exist without a host organisation – then just acts as a service deliverer with satellites.
- Achieves value through providing a specialist service for an organisation unable or not best placed to provide that service itself – value created through efficiency.
- Can be applied to any service, but in services where patient crosses between the host and outreach organisations well-defined liability, protocols and data sharing agreements and clinical governance arrangements are crucial.
- Not geographically defined – typically regional or national scale, potential to have international scale.
- Can be formed through direct outsourcing, joint ventures, networks and other mechanisms, potential to develop franchises.
- Benefits to host organisation: access to expert specialist provision, ability to concentrate on core services, association with a specialist brand (if applicable), economies of scope if increasing the amount of services provided.
- Benefits to outreach organisation: spreads own brand, income creation opportunities, potential economies of scale and scope.

What is the form?

Service-level chain is also known as the hub and spoke form

Service-level chain is a multi-tiered form that uses a standardised governance system. The organisation of the chain is centralised to the hub, and a host organisation uses the services provided by the hub. Service-level chains are led by the Trust Board of the hub/outreach organisation. The hub sets the standards and enforces them, and the satellite, or the spoke, operates as a delivery centre that can be scaled up or down as based on business requirements. The services can be offered on a commissioned or a subcontracting base. If commissioned the hub seeks to engage strategically in the service delivery design with local authorities and clients; if subcontracted the delivery requirements are fixed by the subcontracting authority.



Hub responsibilities:

- Exercises strategic leadership of the satellite/spoke provision
- Defines patient needs and ensures uniform patient experience across satellites.
- Sets quality, risk and performance standards for the spokes and monitors performance.
- Defines and delivers training and ensures uniform capability development between hub and spoke.
- Ensures staffing levels and uniform employee management across spokes, and usually the back office functions.

Satellite responsibilities:

- Extensions of the hub leveraged to provide services to clients – spokes act as delivery centres.
- Accountability: meeting performance and quality standards set by the hub.
- Local project management.
- Making recruitment decisions and adding to staff levels if needed.
- Supports hub on legal, financial and compliance issues during any disputes.

What is the form?

Both the outreach and the host organisations can benefit from the service-level chain – both need equal amount of benefits for the partnership arrangement to work

There are several benefits to both outreach and host organisation, including economies of scope. Disadvantages of the form include potential brand reputation issues, as well as liability when patients cross over between specialist areas.

Hub/Outreach organisation

Benefits:

- Replicate the management and processes, and deliver best practice standards.
- A faster and easier expansion of activities.
- Additional income from additional patients.
- Use the satellites as part of a clinical pathway to direct certain patients to the hub.
- Possible economies of scale from increased operations.
- Possible economies of scope from providing more services within one specialism.

Disadvantages:

- Complex management – setting-up distant sites can be difficult and intermarrying IT systems with host can be problematic.
- Diversion of senior management time.
- Geographical distances making quality and performance management more difficult.
- Transition from single site centre to a hub and spoke form can be complex.
- Legal and compliance related issues when managing multiple locations.
- May not understand local health economy well enough to deliver appropriate services.
- Potential brand reputation damage if associated with poor practices at host organisation – need to choose carefully.

Host organisation

Benefits:

- Gaining access to best practice standards and specialist skills by a specialist provider – can help overall reputation of the host.
- May help in achieving clinical and/or financial sustainability if the hosting organisation is finding it difficult to deliver a certain service.
- Subcontracting fringe services enables the hosting organisation to focus on its core functions.
- Possible economies of scope through increasing services provided/through delivering additional and/or new services.
- Potential rental income if premises leased/patient charge income.

Disadvantages:

- Potential liability issues – who is responsible for patients if they cross the boundaries between different specialist areas.
- Reputational damage to the Trust if quality of the out-sourced service does not meet expectations.
- Setting-up long-term agreements that ensure sustainability to patients may be difficult.
- Patient resistance. Patients may be concerned over the quality of a new provider. Additionally, patients may prefer one type of provider over another (e.g. NHS patients may prefer to be treated by NHS providers and vice versa).
- Staff resistance. Local clinical staff may be concerned over the impact on their work streams, or on other contracted services. Staff may also be concerned over the quality of an “outsider”.

What is the form?

Contractually service-level chain agreements can take many forms – utilisation of assets, workforce, and liability issues are negotiated separately

Assets – premises and equipment	• The host organisation may provide all premises and all equipment or none. • Premises may be on hospital site, community locations or mobile units, and equipment may be provided by host, the outreach, or both organisations jointly. Dependant on capacity and requirements of the host and outreach organisations. • Leasing space and paying for infrastructural support (e.g. electricity), while providing all staff preferred by some providers as it allows them to retain more control over their operations.
Workforce	• The outreach organisation may provide all staff, or staff jointly with host organisation. • Outreach organisations usually provide all staff. This makes it easier for them to manage the quality (through unified training), and ensure liability stays with the outreach organisation. • Some providers require everything (e.g. staff and systems) to be under their control when operating satellites due to reputational risk to their brand.
Ownership and liability	• In principle the satellite location is organisationally separate from the host organisation, with the ownership lying with the outreach organisation. Thus all liability over the quality and patient outcomes falls under the outreach organisation. • However, where the host organisation provides administration, or where the delivery is provided jointly (in whatever percentages) between the host and the outreach organisation, there may be grey areas. • Legal contract must clearly define liability, and how the liability transfers if patient crosses the boundary of the two organisations. • Outreach organisation may also wish to provide corporate medical malpractice and individual malpractice insurances for clinical staff employed.
Regulation	• NHS provider licence (Monitor) held by provider at the headquarters and host where service delivered; normal exemptions apply (Applies to Independent Sector (IS) providers, NHS Trusts exempt, NHS FT will already have). • CQC registration held by the provider (outreach organisation); CQC inspects all the locations providers operates in, publishes an inspection report for each location and then an overall report and rating for the provider. • For the purposes of registration and regulatory oversight, the service provider (outreach organisation) is responsible for the delivery and quality of the service, even when located on premises of other providers. The host organisation is inspected separately, and the service site inspection results do not affect the CQC rating of the host organisation. • Ad-hoc, one-off deliveries of services due to crisis/singular event are usually not regulated due to their nature of being short-term and time-bound, if service concludes before registration can be completed and sites inspected.

What is the form?

Moorfields vs. Newmedica – two different contractual forms for eye care service-level chains

Moorfields – NHS

Statistics: In 2013/14 Moorfields Eye Hospital undertook more than 33,000 episodes of inpatient/day case treatment and more than 470,000 outpatient appointments across its 23 locations in and around London. Approximately 50% of the new referrals are seen in locations other than the Trust's central London hospital.

Workforce and premises: Only uses own staff for directly commissioned activity, partnership working for other service offers. Uses leased premises at host hospital and community locations.

Commissioned vs. subcontracting: Delivers commissioned and subcontracted services – prefers to be directly commissioned (e.g. have strategic negotiations and influence) and have a contract with the hospital to lease space while providing Moorfields staff.

Branding: Has a strong brand that is the key selling point for Moorfields service-level chain. Do not rent out their name as per a franchise, but prefer all components (staff and systems) to be under their control – key concerns relate to quality assurance and clinical governance.

Patient preference: Hub vs. spoke: Some patients prefer to be seen at the hospital in central London (City Road) as they associate this with high-quality research, and are worried that other locations may not provide the same quality services. Thus Moorfields may find it challenging to deliver geographically far-reaching service-level chains as long distances between the central research centre brand and the Moorfields satellites might lead the satellites to lose some of the brand benefit.

Newmedica – IS

Statistics: 2014/15 projection: Delivery of 75,000 patient interactions, 2014: 13 active contracts across England for Trusts, CCGs and IS providers

Workforce: A hybrid form: Prefers to involve local staff in the services. Administrative/support/AHP staff from Newmedica, consultants often local (both contracted via Newmedica or in Trust contracted hours). This is seen to allow integration of pathways and to benefit patient care as decision-making is consistent across Newmedica and the Trust.

Uses host hospital premises where possible (adjusting pricing to reflect availability of premises), or where necessary, community locations and mobile units.

Commissioned vs. subcontracting: Full-service sub-contracting; deliver as per host organisations demands. Engages in strategic negotiation where possible, but as is often brought in to solve an acute problem, short-term focus is usually more relevant. Once acute problems resolved, relationships develop over time to be more strategic, with a focus on service transformation.

Branding: Discovered that patients preferred to be seen by local NHS provider and that NHS patients wanted to remain in NHS care. At the start of their operations they used their own branding but now brand their services with the host organisation or local CCG, minimising the Newmedica brand.

Patient preference: Hub vs. spoke: Not applicable – as Newmedica brands its services in co-operation with the local Trust, patients tend to associate care with their local host Trust/service provider. This may make it easier for Newmedica to deliver geographically non-contiguous service-level chain.

What is the form?

Branding of service-level chains is likely to differ between NHS and IS service providers due to patient engagement effect

NHS-led service-level chains

NHS organisations delivering service-level chains tend to have unique reputations and strong brand recognition associated with high quality patient care and research.

Patients are generally happy with NHS care, and the service-level chains operated by NHS organisations are likely to benefit from using their own brand.

In some cases patients may feel less comfortable if they are treated outside the central Hub that provides the brand value – they feel they are not getting "real" excellence and would prefer to be treated at the centre.

Providing a hosted service may affect working relationships with other NHS Trusts and the hospital, and some Trusts may be unwilling to relinquish control of key services (e.g. cancer, paediatrics). Local clinicians may be unhappy handing over control as may perceive the service-level chain taking work away from them. This may risk the brand reputation of the outreach organisation if not carefully managed.

IS-led service level chains

Patients that are treated at NHS centres generally prefer to remain within NHS care, and may be cautious of external providers delivering services within NHS settings.

Local clinicians may also be wary of IS providers operating within NHS sphere and see IS providers as potentially variable in quality.

IS providers delivering services for NHS providers may find it easier to deliver services under the brand of the NHS organisation due to the patient and clinician engagement aspect. The services can be delivered using the host organisation / CCG brand, or branded as a partnership.

For privately treated patients, or where IS provider brand is sufficiently strong to command brand loyalty the opposite may hold and branding could be done to emphasise IS providers.

What is the form?

Service-level chains are most suitable for stand-alone specialisms, ambulatory care and certain imaging-heavy specialities that can be delivered remotely

Service-level chains are most suitable for stand-alone specialisms and ambulatory care

- It is often suggested that service-level chains are only suitable for stand-alone specialities, such as ophthalmology. The benefits of these specialities are that there is little overlap between the services offered by the host and the outreach organisation, and the patients would rarely cross over divisional boundaries, minimising transfer and liability issues.
- Quality may also be easier for the outreach organisation to maintain, as it does not need to deliver an integrated approach with the host, or deliver administrative notes to the specifications of the host.
- In principle service-level chains should be suitable for a range of ambulatory care services as well. Chronic care, where patient levels are relatively stable and care can be delivered in the community can avoid the liability issues of patients crossing between hospital departments e.g. dialysis services.
- Paediatrics may also have the potential to support service-level chains that run a full paediatric service (as opposed to paediatric specialities within a paediatric unit), as paediatric services are relatively self-contained within a hospital – for example The Children's Hospital of Philadelphia operates a service-level chain in the US.

"Department store" form where a Trust acts as a landlord with the majority of services delivered by external organisations exists but could be challenging to manage

- Host organisations tend to use only one service-chain provider in one specialism. The host organisations invite the service-level chains in to deliver services they do not currently offer, or have difficulty offering.
- It is possible for a Trust to act as a hosting organisation where the majority of the activity on the site is delivered by multiple service-level chain operators, e.g. ophthalmology by one and dialysis by another service-level chain such as the Queen Mary in Sidcup
- However this form has the potential to be challenging to manage. Interface between different service providers needs to be carefully managed as there are culture and infrastructure considerations, particularly if they use different IT systems / patient record systems. Patient cross over from one to another service provider (e.g. from cancer to cardio) could be complex in terms of liability.

Certain technical/image-heavy specialities

- Service-level chains may be suitable for a range of technologically advanced imaging services. If technicians can be used to take images (e.g. glaucoma, stroke imaging, mammography), remote technology could be used to send the images to the hub for consultants to view, deliver care instructions and ask the patient to attend the hub if needed.
- This could facilitate greater operation of certain specialist areas in remote and rural areas.

Case study

Case studies for the service-level chain form

Case study

There are a few notable service-level chains operating in the NHS and there is appetite for establishing more

Moorfields Eye Hospital

- Moorfields Eye Hospital; largest ophthalmic provider in England, in 2013/14 33,000 episodes of inpatient/day case treatment and more than 470,000 outpatient appointments per annum.
- Approximately 50% of the activity delivered in the Trust's 22 satellite locations.

+ Several other examples

Newmedica

- IS operator providing specialist eye care services to NHS.
- Sub-tariff delivery of a NHS branded product.
- 2014/15 projection: Deliver 75,000 patient interactions.
- 13 active contracts across England.

The Walton Centre

- Biggest neurosurgical unit in the country; Partnerships with 13 NHS Trusts and 14 DGHs.
- Hub – The Walton Centre in Liverpool (40% of outpatients); Spoke – c. 50 satellite clinics and ward referral services around the region.

The Royal Marsden

- 2 hospitals.
- Running an outsourced specialist cancer unit with diagnostic and outpatient services in another Trust. Unit operates under a profit share arrangement.

Alder Hey

- Shows appetite to offer paediatric services to other hospitals as part of its 5 year development plan.

Case study

Moorfields Eye Hospital has multiple satellite operations that account for 50% of its activity

- Moorfields Eye Hospital has multiple satellite operations that account for 50% of its activity
- Moorfields is the oldest and one of the largest centres for ophthalmic treatment, teaching and research in the world.
- Moorfields operates from its central London hospital in City Road and in 22 other locations in and around the capital.
- In addition, Moorfields directly manages three commercial divisions: Moorfields Private, Moorfields Pharmaceuticals and Moorfields Eye Hospital Dubai.
- Moorfields workforce consists of more than 1,800 staff.

Moorfields place in the market:

- Moorfields Eye Hospital is the largest ophthalmic provider in England, in 2013/14 undertaking 33,000 episodes of inpatient/day case treatment and more than 470,000 outpatient appointments– approximately double the number of the next largest ophthalmic unit in England.
- In London, Moorfields has 30% market share overall, and delivers 50% of the specialist ophthalmic care.
- Approximately 50% of the activity delivered in the Trust's 22 satellite locations.

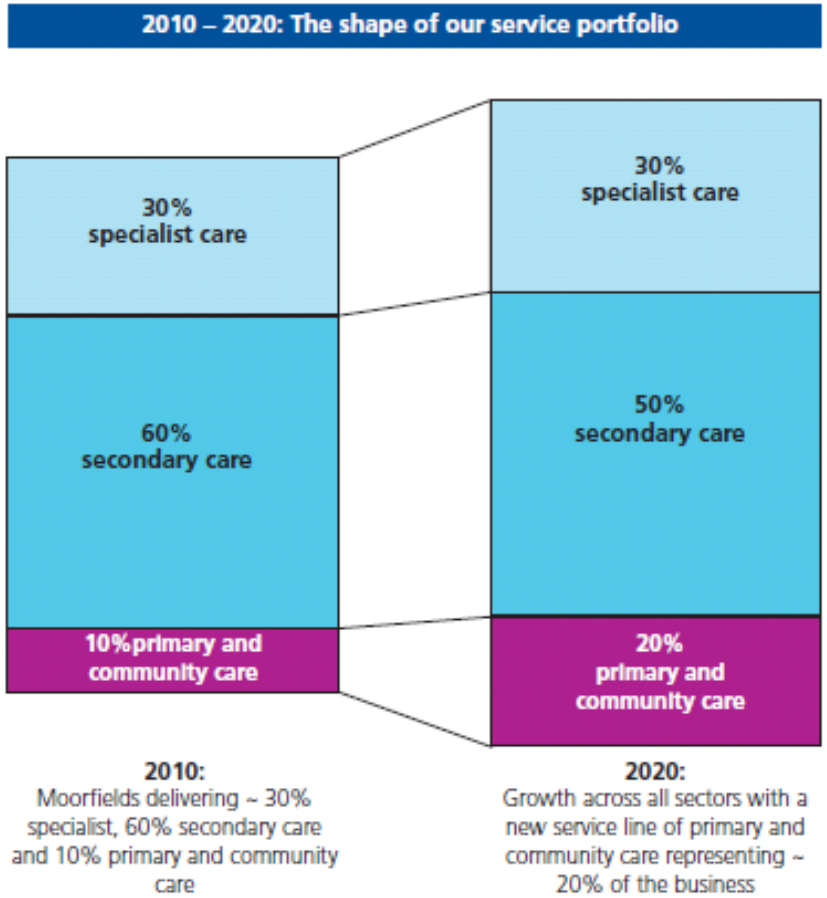


Figure 6: The changing shape of our service portfolio

Source: Our Vision of Excellence, A 10-year strategy for Moorfields Eye Hospital

Case study

… and the Trust is planning to extend its reach further

Geographical Reach

- Moorfields currently delivers its activity in 23 locations in and around London. These locations are grouped into categories as follows:
- *Moorfields Eye Hospital, City Road:* central London base, which provides comprehensive general and specialist outpatient, diagnostic and surgical services, emergency surgery, and a 24-hour A&E for eye problems. Research and teaching activities are also predominantly based here at present.
- *District hubs:* Co-located with general hospital services, district hubs provide comprehensive outpatient and diagnostic care as well as more complex eye surgery and will increasingly serve as local centres for eye research and multidisciplinary ophthalmic education.
- *Local surgical centres:* These centres provide more complex outpatient and diagnostic services alongside day-case surgery for the local area.
- *Community-based outpatient clinics:* These clinics focus predominantly on outpatient and diagnostic services in community-based locations closer to patients' homes.
- *Partnerships and networks:* In this form, Moorfields offers medical and professional support and joint working to eye services managed by other organisations.

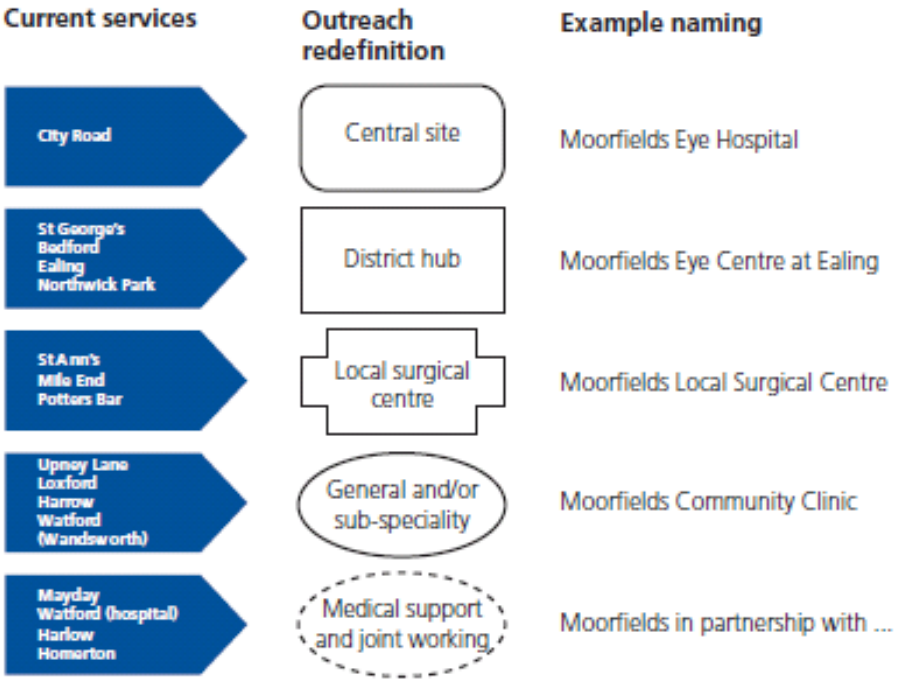


Figure 7: Our generic outreach model

Source: Our Vision of Excellence, A 10-year strategy for Moorfields Eye Hospital

Case study

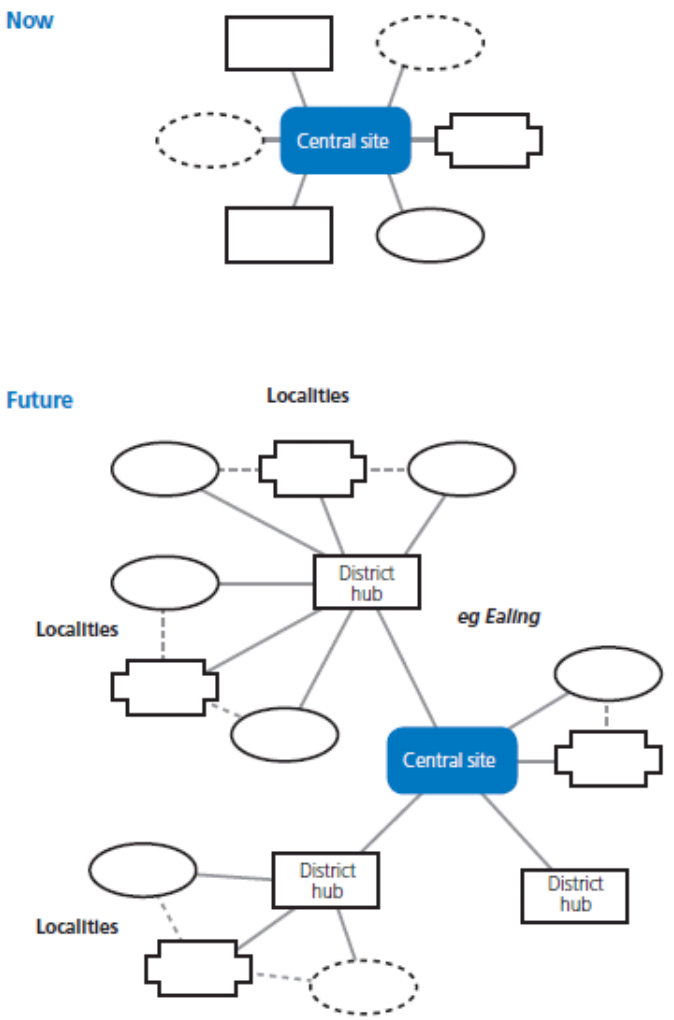
Ultimately, Moorfields is moving towards a networked form of service provision

- Moorfields is currently a hospital-based provider of secondary care for the local population (approximately two thirds of the business) and of tertiary and very specialist care for a regional, national and international catchment population (approximately one third of the business).
- Moorfields strategy suggests that they seek to remain the leading provider of specialist ophthalmic care nationally, but also aim to become a leader in *community-based* eye services.
- Moorfields geographical focus and reach for the future is shifting from form of 'hub and spoke' and transform into a distributed network of more clearly defined facilities.

Governance:

- Moorfields is a Foundation Trust and as such is led by a unitary Board of Directors, which is accountable to the Council of Governors.
- The Council of Governors includes elected and nominated representatives of patients, the public and partner organisations for all of the constituencies that Moorfields deliver services for.
- Below the Board level are strong clinical leadership arrangements, with 4 clinical directorate based around clinical services or locations and led by seven Clinical Directors. An eighth Clinical Director covers quality and safety across the Trust.

Figure 9: Moving to a networked model of service provision



Source: Our Vision of Excellence, A 10-year strategy for Moorfields Eye Hospital

Case study

Royal Marsden forms the largest cancer centre in Europe, operating multiple sites, and has formed several partnerships

The Royal Marsden was founded in 1851 and is a world-leading cancer centre specialising in diagnosis, treatment, care, education and research.

Together with their academic partner, The Institute of Cancer Research, they form the largest comprehensive cancer centre in Europe with a combined staff of 4,628.

The Royal Marsden consists of 2 hospitals, one in Chelsea, London and another in Sutton, Surrey. It has a Chemotherapy Medical Day Unit at Kingston University and provides Sutton and Merton Community Services.

Currently running an outsourced day-centre in another Trust with a profit share and looking to take forward more contracts.

The Royal Marsden FT and Kingston Hospital FT

- Staff from the Royal Marsden run the new specialist cancer unit that provides a range of diagnostic and outpatient services at Kingston Hospital.
- The Royal Marsden medical director has described the arrangement as “very successful” and praised the shared risk and reward relationship in place – the Royal Marsden is holds the contracts and is ultimately responsible for governance and quality at the centre.
- Benefits: For Kingston a new service, for The Royal Marsden closer relationships with Kingston and the ability to deliver the service closer to patients’ homes whilst also retaining capacity at The Royal Marsden for non-Kingston patients. The unit operates under a profit share arrangement.

Partnerships

- Academic partnership with Mount Vernon Cancer Centre.
- Member of both the Imperial College Health Partners AHSN and South London AHSN.
- Part of the London Cancer Alliance, a collaborative partnership to develop an integrated cancer system.
- Joined together with Chelsea and Westminster and Royal Brompton & Harefield hospitals and The Institute of Cancer Research as the Fulham Road Collaboration to establish a joint contract for its soft facilities management services including catering, portering and cleaning (this was awarded to ISS Mediclean following a competitive tender process).

Case study

The Walton Centre is the largest neurosurgical unit in the UK, delivering services via a 'hub and spoke' form

- The Walton Centre is the largest neurosurgical unit in the country.
- The Trust originally formed in 1992, and attained NHS FT status in 2009. It is unique to the NHS as it is the only specialist Neurosciences Trust in the UK.
- Catchment population of about 3.5 million, serving Merseyside, Lancashire, Greater Manchester, North Wales and the Isle of Man. Due to its international reputation in some areas of expertise, referrals are received from other geographical areas of the UK.
- Service delivery is achieved via a 'hub and spoke' form and has partnerships with 13 NHS Trusts, with 15 district general hospitals, across the area it serves.

'Hub and Spoke' form

- 'The hub' – The Walton Centre in Liverpool – where 40 per cent of outpatients are seen.
- 'Spoke' consists of roughly 50 satellite clinics and ward referral services at 15 hospital and GP practice sites around the region –'spokes'.
- There are some non-clinical support functions such as estates and payroll provided through a service level agreement with Aintree University Hospital NHS Foundation Trust (AUH FT).

Services provided and their role in the network

- Neurology – links with the stroke unit at Aintree University Hospital NHS Foundation Trust (AUH FT), and they deliver satellite hospital neurology services to the Royal Liverpool University Hospital.
- Neurosurgery – part of the Cheshire & Mersey Major Trauma Centre Collaborative (MTCC) along with AUH FT and the Royal Liverpool and Broadgreen University Hospitals NHS Trust.
- Pain Management Programme (PMP) pain management and pain relief – contracted anaesthesia staff and pharmacy works from AUH FT.
- Neuro-rehabilitation – from January 2013 this division has hosted the Cheshire and Merseyside Rehabilitation Network, a service which provides both hyper-acute and specialised rehabilitation also via a hub and spoke form. The service includes a collaboration with St Helen's and Broadgreen Hospitals.
- Neurophysiology – They provide electroencephalogram (EEG) tests at the Walton Centre, Alder Hey and the Royal Liverpool University Hospitals.
- Other specialist areas – Pain medicine, Neuropsychology, Neuroradiology, Neuropathology, Critical Care.

The Walton Centre NHS Foundation Trust (2013), The Walton Centre: Excellence in Neuroscience, available at http://www.thewaltoncentre.nhs.uk/uploadedfiles/documents/Trust%20brochure%202013.pdf

The Walton Centre NHS Foundation Trust, (2013) Annual Report & Accounts 2012-13, available at http://www.thewaltoncentre.nhs.uk/uploadedfiles/documents/Annual%20Report%20201213.pdf

Case study

Newmedica is an independent sector operator delivering specialist eye care services to NHS Trusts under NHS branding

Newmedica

- IS operator providing specialist eye care services to NHS
- The largest (by volume) IS ophthalmology provider to the NHS
- Backed by Consultant Eye Surgeons Partnership (CESP) – a nationwide partnership of c. 250 NHS and private ophthalmologists (accounts for c. 20% of UK consultant ophthalmologists)
- Sub-tariff delivery of NHS branded product

Types of forms

- De novo start-up ophthalmology services
- Capacity solutions
- Migration of existing services to community locations
- In situ transformation of whole hospital ophthalmology departments

2014/15 projection

- Deliver 75,000 patient interactions
- 13 active contracts across England
- Delivers services from fixed sites (Trust facilities or community locations) and from small and large mobile units (special-purpose built trucks/trailers)
- Hospital facilities used when available (and pricing of services reflect if location offered); 5 mobile units can be deployed to community areas closer to patients

Range of services

- Patient triage
- High volume general clinics
- Cataract pre-op and post-op clinics
- Retina clinics
- Glaucoma monitoring
- ARMD assessment and injections
- Paediatric OPD
- Orthoptics
- Neonatal ROP Screening
- Cataract surgery
- Oculoplastics surgery
- Motility surgery

Newmedica

Case study

NHS branded services by Newmedica – Ipswich & East Suffolk branded Newmedica i-van

Community glaucoma review – a mobile "i-van"

- Newmedica were sub-contracted to deliver eye care services at Ipswich and East Suffolk as the hospitals struggled to find capacity to do glaucoma reviews. On average patients attended 2.75 times to do all necessary tests.
- How it works: The mobile unit is based in Ipswich Hospital's car park and sees up to 20 patients a day. Optometrists / clinical assistants gather data, data is recorded electronically and then checked by ophthalmologist using a web-based system (meaning ophthalmologists can also work remotely). Historical data from hospital notes also digitised. Up to 20% of cases the consultant makes changes to optometrist suggested management.
- Van and equipment owned by Newmedica.
- Staffing: Optometrist, two clinical assistants, administrator and consultant reviewer. Newmedica employs the optometrists and managerial administration.
- Van branded with the local CCG and alterations done to the local specifications. Newmedica has found that NHS patients prefer to remain within NHS services and so have started branding their services with CCG after patients were not receptive to being treated by a private provider.
- Some consultants less happy as feel work is taken away from them.

Newmedica

Community glaucoma review – a mobile "i-van"

- No local start-up costs as all included in agreed local price.
- Savings made through paying reduced percentage of the follow-up outpatient tariff, and through reduced number of appointments as all tests are done sequentially on the same day. Previously patients might have had to attend the clinic on separate days, meaning increased number of DNA's.
- Savings Activity base 5,000; "Annual savings against tariff are circa £35k + reduction from 2.759 appointments at national tariff to one appointment at local tariff, a fall from £664,125 to £206,325. Total saving for first year is circa £500k."
- Outcomes: Positive patient feedback. All tests done in one day. Care closer to home. Waiting times 4 weeks. Consultant reviews take place within seven days.

http://www.pulsetoday.co.uk/home/practical-commissioning/a-mobile-clinic-for-glaucoma-patients/20002027.article [Accessed 24/07/2014]
Havard, John (2013), A Mobile clinic for Glaucoma Patients, practicalcommissioning.net, Pulse, March 2013

Case study

Alder Hey – Appetite for providing a range of paediatric services for other Trusts

Alder Hey

- One of Europe's busiest children's hospitals.
- Care for over 270,000 young people and their families every year.
- A Centre of Excellence for cancer, as well as spinal, heart and brain conditions.
- A Department of Health Centre for Head and Face Surgery.
- A Centre of Excellence for Muscular Dystrophy and the first UK Centre of Excellence for Childhood Lupus.
- One of four national centres for childhood epilepsy surgery, a joint service with the Royal Manchester Children's Hospital.
- A designated Children's Major Trauma Centre.
- Alder Hey have Europe's only intra-operative 3-T MRI scanner which is a pioneering technology for neurosurgery, reducing repeat operations in 90% of cases.

Alder Hey @ service-level chain in the future?

- Currently delivers over 600 of paediatric specialist clinics in North-West England and North-Wales.
- These clinics offer a wide variety of services from specialist clinics to full service paediatrics.
- Currently the clinics are operated within DGHs paediatric departments.
- Alder Hey has good reputation in the region and expertise in children's services.
- Show appetite in expanding their service form, and are exploring different arrangements with regional hospitals in delivering care at local communities.

Case study

Other examples of service-level chains in UK

The Christie NHS Foundation Trust (Manchester)

- Radiology department – undertakes over 40,000 examinations over the year, general radiology, CT and MR scanning, ultrasound, interventional radiology and nuclear medicine.
- Established a network of The Christie radiotherapy centres.
- 2 satellites; 1 in Royal Oldham Hospital treating breast and prostate cancers with more common cancers to follow and 1 in Salford Royal NHS Foundation Trust treating common cancers.
- Rare and complex cancers treated at The Christie main hub.

Other examples

Newcastle upon Tyne Hospitals FT and North Cumbria University Hospitals Trust

- As an interim measure NHS England asked Newcastle FT to support radiotherapy services in Cumbria after operating difficulties emerged.

Medway NHS FT and Harris Birthright Centre

- Foetal medicine service at Medway run by Harris Birthright Centre that provides a weekly consultant-led clinic for suspected abnormalities and multiple pregnancies.

Renal Services

- Independent dialysis provider, operate dialysis facilities, privately owned and on behalf of NHS.

http://www.christie.nhs.uk/about-the-christie.aspx, Barnes Sophie, and West David (2014), Hospital chains win backing of national leaders, LGC 14th February 2014, available at http://www.lgcplus.com/briefings/joint-working/health/hospital-chains-win-backing-of-national-leaders/5067979.article, http://www.medway.nhs.uk/our-services/maternity-services/antenatal-care/antenatal-screening/, http://www.renalservices.com/

Key considerations

What are the scenarios in which the form could apply?

Service-level chains are a flexible form and can be used in a wide variety of different situations and locations

Geographical factors	• In principle service-level chains can operate in cities, town, rural and remote areas; wherever there is the need and the sufficient patient flows for the service. • However, monitoring quality, attracting qualified staff and using satellites to direct patients to the hub (if applicable) is more difficult in remote and rural locations due to distances involved. Available local knowledge to enable efficient service-delivery may also be more scarce.
Financial and clinical sustainability	• Service-level chains are led by high-performing organisations capable of delivering and spreading high standards of care to host organisation level. • Host organisations looking to improve a service may benefit from the experience of the outreach organisation. However, if the host organisation has serious financial/other difficulties, outreach organisations may be wary of the association with them as they can consider it to risk their brand. • Service-level chains can help in achieving financial/clinical sustainability if they address delivery problems in host organisation.
Services offered	• To set up a service-level chain in a new location there must be sufficient patient flow to warrant the investment. • In services where the patient crosses departmental boundaries, contracts must be clear on liability and the transfer of liability in such cases. • Ambulatory care service-level chains have fewer issues with liability as patients usually do not need to be transferred. • Consultants in the hub can have remote access to imaging, satellites can use technicians to do image-taking.
Interactions with other forms	• Service-level chains could in principle be operated by any form. • All models could in principle act as host organisations. • Single and multi-site Trusts most likely to lead and host service-level chains, as operationally they have a well-defined leadership models that ensure clear levels of liability. Federations the least likely to lead SLC. • Joint ventures have the most potential to grow into a service-level chain, if they have already proved their performance standards and best practice cases.

Key considerations

Does the form apply across some or all geographical circumstances?

Service-level chains can be used in a wide variety of geographical areas, but may be better suited to local and regional areas

In principle service-level chains can be set up anywhere, from cities to remote locations, depending on the service

- Service-level chains could potentially operate across a wide variety of geographical areas ranging from local to international. Service-level chains are also applicable to a number of different geographical structures, such as urban and suburban metropolitan cities through to isolated rural areas.
- Service-level chains are able to utilise intangible assets, such as standardised procedures, human capital and training initiatives as well as established clinical pathways to drive efficiency and disseminate good practice at the local level. The ability to use local hospital infrastructure, equipment, and other back office and support functions will also make it easier to set up service-level chain locations in distant locations.

Satellites in rural and remote locations offer patients better access to specialist care

For rural locations service-level chains may be particularly attractive as it may be impossible to grow and develop certain specialisms and attract talent capable of contributing to that domestically. Where technology enables remote access to patient data (such as eye services) service-level chains offer the advantage of better access to specialists.

Remote satellites may suffer from difficulty in staff recruitment and quality monitoring, and may not work well as part of a clinical pathway

- Most service-level chains are headquartered in cities and based regionally. This enables the satellites to benefit from the brand of the hub, proximity to the hub facilities and unique selling points, such as research centres or specialist staff. Setting up service-level chains in locations far away from the centre exposes the outreach organisation to some risks, which may lessen the appetite for remote satellite sites. Monitoring quality at remote locations may be more difficult, presenting a reputational risk to the outreach organisation. Recruiting qualified staff may also be more difficult. Furthermore, if the outreach organisation plans to use the satellites as a starting point of a clinical pathway through which it directs some patients into its centre, remote locations from where patients may be less able to travel from are less attractive.

Rural and remote satellite management requires understanding of the local conditions and well-defined standardised procedures

- Strong leadership capability, well-defined and standardised procedures and provision of own staff, particularly at managerial levels, helps in instilling the desired standards at remote satellites. The outreach organisation may also find it challenging to know the requirements of local population when it does not have local knowledge – a commissioning approach working in strategic partnership with local CCGs and hospitals can mitigate this risk.

Key considerations

Does the form apply across different health economies?

Satellites can exist as part of a local Trust or stand-alone units, and be NHS or IS, as long as there are sufficient patient flows to ensure sustainability

Service-level chain satellites often are part of a multiservice site, but could act as stand-alone units as well

Service-level chains are usually conducted in a partnership with a host organisation, on or near their premises. In principle if there is a need in the community for a particular service, the service-level chain could be set up in a community location, independent of other health services. This would enable the service-level chain to use the satellites as a part of a clinical pathway to direct patient traffic towards the hub, with less need to manage relationships with local hospitals / clinicians.

Patient flows must be sufficient for the service-level chain form to deliver the required benefits to outreach and host

The form can potentially be delivered in all different health economies, even where activity levels are varying. There are examples of occasional clinics (2-3 per week) being set up in areas where activity levels are relatively low. However, activity levels must be sufficiently robust to ensure the feasibility of operating a satellite and covering the costs. Chronic care conditions may offer the most stable patient flows.

Competing providers entering or exiting the markets may affect patient flows to the service-level chain satellites

If new specialist providers entered the market to the extent that there would be less patient flow towards the service-level chain satellite, this would affect the profitability and sustainability of the service. However, if the service-level chain has brand value or has already otherwise captured the market, there is less incentive for other providers to enter the market at that location.

Both NHS and IS providers can act as outreach and host organisations.

The form can be used by both NHS and IS providers, either as host or outreach organisations. There are examples of each type of service-level chain provider in the UK health care sector.

Key considerations

To what extent does financial and clinical performance determine whether the form is suitable?

Both outreach and host organisations need to be sustainable, or concern over brand and reputation could mean partnership arrangements are more challenging to agree.

If the host organisation faces chronic challenges, partnership between the service provider and the host organisation is unlikely to be agreed

- Outreach organisations delivering service-level chains are primarily high performing organisations that consistently deliver high standards of care and also have the capability and capacity to replicate these standards in new sites, which potentially lie in organisations struggling to provide the required specialist service.
- Organisations that have very large financial problems and/or those located in local health economies that face significant challenges beyond the boundaries of the organisation may not be suitable to become hosts to a service-level chain. The host organisation may also need to provide (dependant on contract and arrangements) suitable premises and equipment. Outreach organisations, particularly where they are keen to protect their own brand and reputation, are less likely to enter into an agreement with Trusts in financial and/or other difficulties. IS service-chain providers using local branding may be more willing to enter into such agreements.

Where clinical or financial problems stem from one particular service-line, service-level chains can help

- Service-level chains can address both clinical and financial concerns. Hospitals that are expert at providing for acute problems may struggle to provide consistent chronic care, and in this setting service-level chains may be beneficial. Additionally, if an organisation finds providing a certain service too costly due to lack of specialist skills or equipment on-site, or has a backlog of patients, bringing an outsider with the necessary skills to set up specialist services may be helpful.

Service-level chains cannot be used to resolve widespread and deep-seated challenges in the host organisations and local health economies

- Service-level chains will not be able to help an unsustainable organisation to become viable, as they only deliver improvements in certain specialised areas. Where unsustainability stems from a particular clinical or financial issue related with that specialism, or inability to provide chronic care management, service-level chains are helpful.

Key considerations

What is the role of organisational leadership in the form?

A collaborative approach is crucial to ensure success of the partnership, and organisational leadership requires both strength and vision to implement changes.

Service-level chains are collaborative in approach – they need to be invited in and work as partners.

- Service-level chains are by necessity collaborative, particularly if they are subcontracted or working as part of a hospital on a commissioned basis. Most existing service-level providers emphasise that they need to be "invited in" before they would agree to set up a satellite at a location, because there can be local resistance (from staff and patients) to an outside organisation coming in unsolicited. There may be concerns over the patient flows, the impact on internal and external staff work streams and other providers in the local health economy may be concerned over the impact on their work. This opposition may affect the feasibility of the service-level chain.
- If a service-level unit is delivering a stand-alone service without a partner in the local health economy, then the chain could acquire local units / service specialists in order to grow its reach.

High-performing organisations capable of transferring and implementing best practice standards lead service-level chains.

- Service-level chains are usually led by a high-performing organisation capable of delivering good standards of care and transferring these to satellites outside the hub. The host organisations may have a lower performance standards in that particular speciality, but overall are likely to be stable organisations. It is unlikely that an outreach organisation would agree to set up a satellite at a host experiencing serious financial/clinical difficulties as this could present risks to their reputation and brand.

Leaders of service-level chains and their hosts need to understand local health economy, and be visionaries in delivery and implementation.

- Strategic understanding of the local health economy and the host organisation is required from the service-level chain hub. As service-level chains are a relatively underused option in NHS, the host organisations have to have leaders visionary enough to try new options. Host organisations also need strong and persuasive leaders to drive through changes and gain buy in from staff.

What is the impact on the Trust Board or FT Governors?

- Additional risk to consider (both outreach and host organisation); for outreach organisation there can be a considerable diversion of senior management time when setting up and day-to-day running of operations.

Current governance options enable the form to develop widely

- There are several examples of service-level chains in UK (both by NHS and IS providers).

Key considerations

Does the organisational form interact with other organisational forms or is it a stand-alone form?

Service-level chains are highly adaptable and can operate from/in nearly all forms in appropriate circumstances, including through hybrid approaches. Service-level chains can be hosted by all other forms, and delivered by most – the best fit is with single and multisite Trusts, joint ventures and integrated care organisations. In theory, it is also possible for a service-level chain to be delivered by or hosted by a mutual, however there are currently no relevant examples of this practice in healthcare.

Hybrid with	Service-level chain (SLC)
Single and multi-site Trust	• Yes: Single or multisite Trust can act as either an outreach or host organisation to a service-level chain.
Multi-service chain	• Yes: Multi-service chain can use the services of a service-level chain. • Maybe: Multi-service chain could in theory also lead a SLC as an additional venture, if the multi-service chain had strong specialist skills, but due to senior management diversion time may unlikely to be feasible.
Joint venture	• Yes: Could be established on the best practice standards achieved through a successful joint venture. Large potential as SLC is not limited by existence of clusters of local Trusts, but can expand to any organisation.
Federation	• Yes: An organisation in a federation could run a SLC. • Maybe: A specialist federation could in theory set up SLC or JV to deliver specialist care, but feasibility of this questionable as you would need well-defined limits on organisational leadership due to liability issues. Difficult to do in a federation, particularly if loose arrangements.
Management contract	• Yes: Trusts under management contract may act as hosts to a service-level chain. • Maybe: Specialist providers under management contracts may in theory operate an SLC. In practice, management contracts are usually used in Trusts with financial/managerial concerns. Running an SLC requires strong leadership because of diversion of senior management time, and Trusts with existing difficulties would likely not be able to take on an additional challenge or be able to export their brand.
Integrated care organisation	• Yes: ICO can use the services of a SLC. • YES: ICO could set up a SLC to deliver certain care (for example ambulatory care) in several locations in the relevant health economy it operates in.

Key considerations

Does the form pass the three sense checks?

Service-level chains have been done in the UK, have made a difference, and can be done in the future as well.

Does it make sense in the context described?	• There is evidence of successful service-level chains in the UK healthcare sector. The NHS has both independent and public sector operators providing service-level chains, and there is appetite in the sector for more service-level chains to be set up.
Will it make a difference?	• Service-level chains can take pressure off from Trusts with challenges in providing certain services; they can enable the host organisation to focus on their key services, with the potential to improve the clinical and financial performance of the host Trust. For the local community the benefits can include higher quality standards, improved service portfolio, increased patient benefit through greater access to specialist providers. For the outreach organisation the form is likely to bring financial benefits and in certain cases increase their brand prestige. Outreach organisations can also benefit from economies of scale, and through using the satellites as part of clinical pathways to direct appropriate patients to the hub for further treatment.
Is it feasible?	• Service-level chains are present in the UK healthcare sector, so they are feasible. Geography and the service specialism provided may be constraining factors. Service locations far from the service provider headquarters may be more difficult to manage. Where patients cross the boundary between outreach and host organisation, liability arrangements must be well-thought through.

Key considerations

Are the motivations to develop the form primarily defensive or strategic?

Economies of scope and scale, capturing new patients and markets and brand development are key motivators for development of service-level chains.

	Defensive motivations	Strategic motivations
Host	• To maintain provision of specialist services where difficult to do (e.g. DGH that find it difficult to provide specialist services efficiently) • To deliver new services/improving service offering to patients. • To capture more patients/patients from other providers.	• Potentially achieve economies of scope if adding to services provided in the organisation. • To focus on key objectives/areas, and leaving fringe services to specialist providers. • Access the brand status of a specialist provider. • Provide safer services and better outcomes for patients, if finding it difficult to provide certain specialist services on their own.
Outreach	• Create clinical pathways in new areas that filter patients to the hub. • Avoid other competing service-providers from entering the same markets.	• Potentially gain economies of scale through increased service provision. • To deliver more services within specialist subject, and gain economies of scope. • To improve their brand reputation – wider distribution of their services and being seen as centres of excellence in the field • To meet demand – DGHs may struggle with providing certain services that outreach organisations could provide.

Key considerations

Are the barriers to the form primarily technical, strategic or a mix of both?

Unclear contracts, patient preference, consultant engagement and competition between hospital Trusts must all be well thought through to enable development of service-level chains.

	Technical barriers	Strategic barriers
Host	• Contract: lack of clarity on reporting lines, accountability, patient liability and performance management – contracts need to clearly label what is under outreach and what is under host organisation responsibility. • Patient preference: patients may prefer certain type of providers according to local experience. Where appropriate, branding the services with the local host Trust / in partnership with the local host Trust may help. • Where NHS Trusts act as hosts to an independent sector outreach organisation, compensation claims from poor service might fall on NHS – if the contract was not clear on indemnities, or where compensation claims high enough to bankrupt IS provider. • TUPE of staff to the organisation and risk of redundancy liability	• Unbalanced relationship between potential partners – both need equal benefits and an equal voice for the relationship to work. • Competition between hospitals may limit appetite for partnership arrangements like service-level chains. • If the service-level chain is in an essential service or central function of the hospital, such as cancer, the host may be less willing to outsource that area.
Outreach	• Contract: lack of clarity on reporting lines, accountability, patient liability and performance management – contracts need to clearly label what is under outreach and what is under host organisation responsibility. • IT and sharing information between the organisation may be technically difficult. • Diversion of senior management time: Establishing and day-to-day running of operations likely to be time-consuming. • Geography: if the outreach Trust wants to use service-level satellites as clinical pathways to the hub, the satellites need to remain relatively local. • Host organisation may not hand over enough control to the outreach organisation – risk to the reputation of the outreach. • Patients may not embrace satellites, as do not see them as the “real” hub services – may prefer the outreach organisation hub. Issue when services branded.	• Understanding of the host organisation and the local health economy – there may be practical difficulties that outsider organisation finds challenging to estimate. • Unbalanced relationship between potential partners – both need equal benefits and an equal voice for the relationship work. • Competition between hospitals may limit appetite for partnership arrangements such as service-level chains. • Local resistance; local staff and other healthcare providers may be concerned over the impact of an external healthcare provider on their work streams. This may lead to reduced cooperation with the outreach organisation. • Hosts may be unwilling to enter service-level chain arrangements for key and central hospital services (e.g. cancer, paediatrics).

Key considerations

What support and incentives might be helpful to further the spread of the form?

Awareness of the form, legal support for contracts and clarity over regulation would support greater prevalence service-level chains in the NHS.

	Support	Incentives
Host	• Guidance in setting up contracts that ensure liability is clearly defined as well as long-term patient service sustainability. • Awareness of the service-level chain form – currently not well-established in NHS. • More guidance on commissioning and regulating the providers. • Greater recognition of benefits of service-level chain. • Understanding which organisations provides high quality in each speciality.	• Ability to attract high quality clinical staff to their organisation, which may not have been available to them previously. • Ability to deliver more complex and higher quality care for their patient population through the relationship and access to the services from the outreach speciality provider. • Should be based on a mutually beneficial business case.
Outreach	• Guidance in setting up contracts that ensure liability structures, how to manage malpractice insurance in service-level chains. • Awareness of the service-level chain form – currently not well-established in NHS. • Brokerage: support in identifying host organisations in demand of services – e.g. Trusts that experience difficulty in providing certain services.	• Expansion of scale and scope. • Commercial opportunities. • Building of reputation.

Management contracts

Management contracts

What is the form?

Management contracts and operational franchises delegate responsibility for running part of or whole organisations to another organisation

Management contract

The terms management contract and operational franchise are often used interchangeably when discussing these options in the NHS context. While there are differences, the legislative framework for NHS Trusts and FTs is such that any external management must sit within or underneath the existing governance roles and structures. This Review therefore uses the term management contract to capture the general principles of the options as they are most likely to apply.

What is the form?

Management contracts are commonly thought of as a means to address financial distress in NHS providers, but their potential uses are much wider

Organisational sovereignty	Assets	Intangibles	Range of services	Scale
Lead organisation gives up some or all of internal control but sovereignty maintained.	Management of assets by contractor.	According to contractor: standardised practices across sites under management.	Up to full range.	From single service to whole organisation(s) at national level.

Key features:

- In English NHS, formed due to operational or strategic difficulties.
- Internationally may exist as standard form e.g. by publicly arranged administrative concession (Alzira) or between private providers (US context) but generally to provide management expertise where previously insufficient.
- External management provides standardised managerial form to improve performance.
- May be shared or centralised services to provide economies of scale, depending on contractor.
- No asset transfer.
- Incentives for contractor may be management fee or profit share arrangement (or combination).
- Value achieved through providing previously inaccessible expertise in financial control, standardised processes, some consolidation of non clinical functions.

What is the form?

The form can offer many benefits of structural mergers but with less upheaval and potentially reduced risks

- Management contracts fall between the more voluntary collaborative arrangements (federations, shared services, buddying) and fully integrated chain or multi-site Trust forms. The form can offer many of the benefits of the fully integrated forms but with greater staff and public acceptance, flexibility and impermanence. However, because of this flexibility and variation in form it is more difficult to establish and maintain appropriate governance and accountability and must therefore be approached with caution.
- Evidence from the USA – where it is a long established form – suggests the reasons for hospitals entering management contracts vary, but thematically cover a need for expertise beyond that currently available to the hospital. Cited reasons include reporting demands, additional capacity while resolving disputes or to plan expansion, and most frequently financial difficulties.
- The managing organisation will have an existing corporate structure providing expertise and capacity in a range of fields which they can draw on in each managed organisation. This will particularly include financial, strategic, human resource and other administrative functions but can also include clinical expertise. By entering a management contract the hospital is therefore able to draw on a support base which would ordinarily be unavailable to them.

Alexander JA, Lewis BL. Hospital contract management: a descriptive profile. Health Serv Res. 1984 Oct;19(4):461–477.

What is the form?

Sao Paulo experienced improved performance indicators following adoption of management contracts in state hospitals, but the translation to the NHS is unclear

In the late 1990s, São Paulo's state government began contracting private entities to manage public hospitals under a State Social Organisation (OSS) form.

This form is based on three elements:

(1) the use of management partnerships,

(2) management contracts with the State Secretary of Health (SES), and

(3) regulation by state government. Hospital management partners are institutions with recognised capabilities to manage hospitals, such as universities and philanthropic organizations. The management contracts are comprehensive and include distinct evaluation and reporting requirements.

The OSS hospitals produced more patient discharges; used hospital facilities more intensively, contracted fewer medical services, and had lower average costs per patient. At the same time, the OSS form improved quality by guaranteeing patient integrity and establising medical quality protocols. OSS hospitals also employ a higher number of qualified personnel and make more efficient use of existing hospital facilities. At the same time, OSS hospitals have lower costs for some specific medical services (La Forgia and Couttolenc, 2008).

Better outcomes in OSS hospitals are attributed to several of the form's characteristics. OSS hospitals have more autonomy in selecting and contracting managers, allocating budgets, hiring and firing personnel, defining and paying for performance incentives, and managing contracts with suppliers. They are financed mostly by global budget schemes and provide for better monitoring and evaluation of contracts, and flexible bidding processes. At the same time, the OSS form provides more space for better monitoring and evaluation by the central government, by providing electronic data on outcomes linked with health goals agreed between the OSS and the SES.

WORLD BANK GROUP

However it is not clear whether these effects would translate to the English NHS, where there is already a highly professionalised management workforce. It would be most appropriate to consider the form on a case by case basis in individual hospitals e.g. where they have recruitment difficulties.

Andre Medici & Robert Murray, 2010. "Hospital Performance and Health Quality Improvements in São Paulo (Brazil) and Maryland (USA), " World Bank Other Operational Studies 10179, The World Bank.

What is the form?

These forms are established options in other health systems and sectors, but are relatively unknown and unused in the NHS

Contract management is a formal arrangement whereby a hospital hires an outside organisation to provide comprehensive management of the hospital's operations. Key elements of this arrangement include:

(1) the retention of policy control and asset ownership by the managed hospital;

(2) the appointment of the hospital administrator and other key management personnel by the management organisation, subject to hospital board approval; and

(3) board approval of the hospital operating budget and all major changes in hospital operations

Lowe JM. Contract management of health care facilities: structural models. Health Care Manage Rev. 1981 Fall;6(4):17–24

In the NHS the form is seen as an option to achieve **transformational change to improve quality, financial management and/or efficiency in situations where the host organisation is fundamentally viable**; it does not involve significant service reconfiguration. Given this, it is regarded as an eventual solution to address previous failures rather than as one of the standard operating forms available.

This is not necessarily the case; there is scope for wider applicability of the forms in both struggling and successful organisations and between all provider types.

The initial experience in the USA of management provision was to hospitals in serious financial trouble. However this increasingly changed to include hospitals reacting to increasing pressures to control costs. It is possible this trend will be echoed in the UK and that there will be increasing interest.

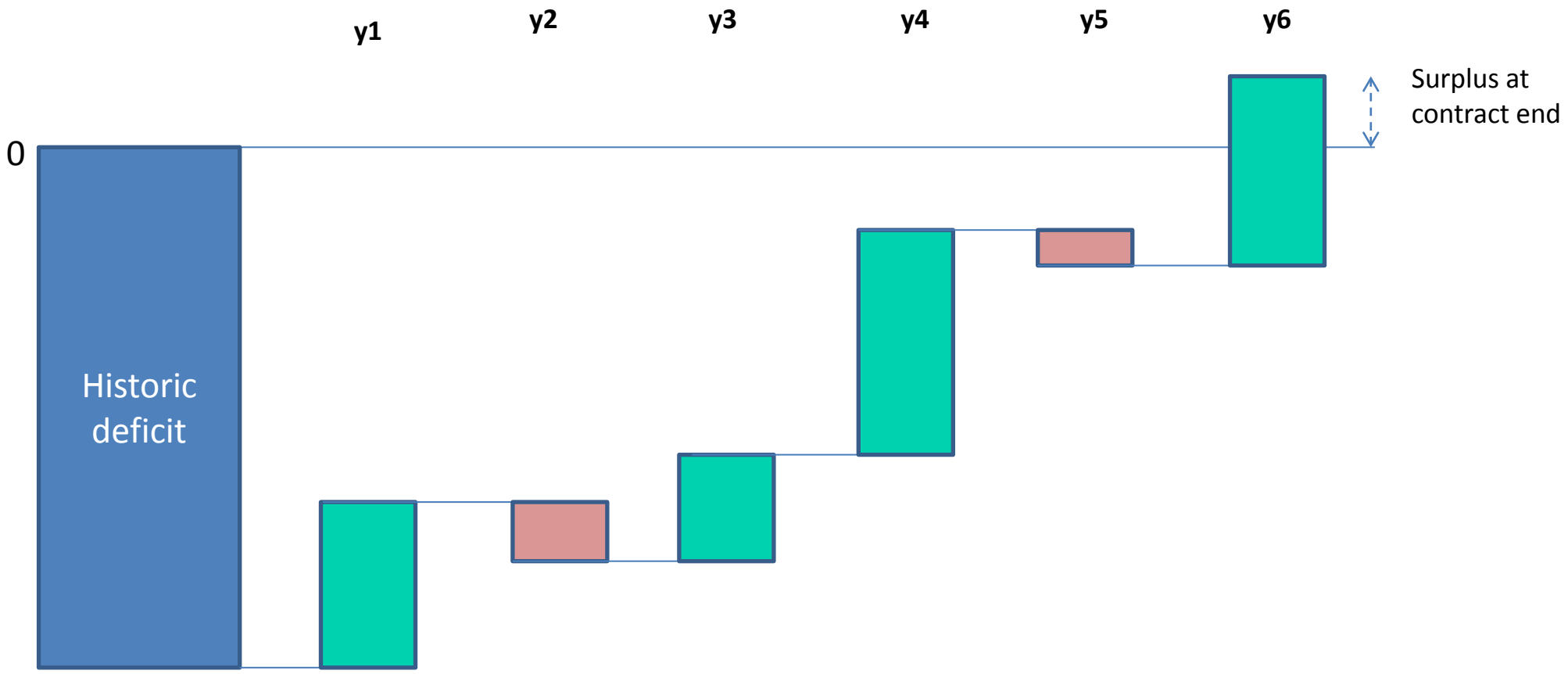
What is the form?

Contracts can cover all or part of an organisation; there are different motivations, barriers and incentives relevant to each option

Whole organisation	**Management of the whole organisation is delegated to an operating entity.** • Depending on the form, there may be full delegation of responsibility to the operating entity, or a Board may remain and retain overall accountability. • Considered to address historic sustained performance issues, both clinical and financial. This form currently only exists in England at Hinchingbrooke Healthcare NHS Trust, with Circle holding the operating franchise. As the legal minimum Board remains at the NHS Trust, the contract is considered a management contract under definitions used in this pack.
Single site of wider organisation	**Management of a site is delegated to an operating entity, with overall governance and accountability remaining with the host organisation.** • May be used to address capacity or capability issues to allow focus on core site functions, or could offer method of expansion through partnership with property or operating company. • This option does not currently exist in the English NHS, but there is emerging interest in the flexibilities offered. The legal form and management could be similar to joint ventures.
Service level	**Management of a service line is delegated to operating entity; governance and accountability can sit with either organisation depending on arrangements.** • Most applicable in specialised and relatively self-contained services; may be used to form service level chains. Outreach organisation benefits from greater footprint and possibly economies of scale. • Can allow Trusts to maximise use of estate or divest of challenged services while maintaining provision for local population e.g. to address availability of specialist consultants. • This is being explored in more detail as part of the service level chains form.

What is the form?

Over the contract duration, the deficit should be reduced even this cannot occur in every year of the contract



The contractor will bear some risk for financial performance and will share any deficit or surplus made from the baseline over the contract duration.

The proportion and timing of their payments will depend on the contract; it may be primarily a management fee with a performance related element, or primarily performance related.

What is the form?

The process for adopting a management contract or franchise agreement is different in NHS Trusts and FTs

FT	• FTs have general powers to enter into contracts which would include taking on a management contract in an NHS Trust or another Foundation Trust (see FT general powers under section 47 of the 2006 NHS Act). • The contracts would not be the same between two Foundation Trusts as with a Foundation Trust and an NHS Trust as the legal framework and therefore the Council of Governors will remain in the case of the former. • A management contract at an FT must not run contrary to the duties of FT directors and governors as set out in Schedule 7 to the NHS Act 2006, so there are limits on the type of arrangement that can be put in place. • It is possible to enter a management contract at an FT where directors still retain their decision making role and remain accountable to the governors e.g. through a partnership committee.
NHS Trust	• NHS Trusts have general powers to do anything which appears to it to be necessary or expedient for the purposes of or in connection with its functions and in particular it may enter into contracts. • In addition, the Secretary of State for Health (SofS) has significant powers over NHS Trusts and may make an intervention order, including to bring in a management contract, if the Trust is not performing one or more of its functions adequately or at all. • NHS Confed suggest the most likely mechanism to be used for Trusts would be an NHS Trust 'shell', which would retain the property, the staff, any protected assets and ultimate accountability. • This is the form at Hinchingbrooke. In addition, SofS reduced the Hinchingbrooke Board to the statutory minimum to allow Circle greater operational autonomy.

What is the form?

Wider use of management contracts could be a longer term solution in some circumstances

Long term use of management contracts could provide a mechanism for high performing organisations to spread their reach without taking on the same level of risk of a full merger or acquisition.

FT	• Assuming an appropriate governance and accountability structure is in place, there is no reason an FT could not – in principle – be operated under management contract indefinitely. • Management contract is not just an option for the independent sector but can equally be operated by a Foundation Trust to enable them to expand their reach non-contiguously. • Assuming control over another NHS body could be undertaken by an FT through its current governance arrangement or through the creation of a special purpose vehicle.
NHS Trust	• Although there are no particular limitations for management contract duration in NHS Trust, under broader FT policy direction, long term management contracts may result in anachronistic Trusts existing beyond the life span of their cohort. This is particularly relevant given the necessary contract duration for these forms. Once all NHS Trusts have changed designation, a permanent solution for those under management contract needs to be found. • Provisions exist in the 2012 H&SC Act (s179) to enable an NHS Trust whose functions are exercised under a franchise agreement to remain an NHS Trust after the repeal of the NHS Trust legislation. A Trust could also retain its NHS Trust status for up to three years after the franchise contract had ended in order for it to be authorised as a foundation Trust, or for an alternative solution to be found. • Potential alternative solutions could include merger/acquisition with an existing FT or more transformative options dependent on wider changes.

Case study

Case studies for the management contract form

Case study

The only current example in the NHS is at Hinchingbrooke Health Care Trust, under management by Circle

Hinchingbrooke Health Care NHS Trust

Circle

Hinchingbrooke Health Care Trust became the primary example of an NHS hospital franchised to a private company in November 2011 under a 10-year deal with Circle.

Hinchingbrooke is a small district general hospital with a turnover £107m and serves a 160,000 population. The Trust has suffered financial difficulties and, between 2004-05 and 2007-08, developed a cumulative deficit of £39 million on an annual income of around £73 million.

The process for awarding the contract at Hinchingbrooke took 180 weeks from options development to contract being awarded.

Circle brought a distinctive culture and management approach and a clear understanding of its business form. The senior team emphasise their focus on customer service and engaging staff in transformation.

There were some significant successes in the first year. Circle has dramatically improved the look and feel of the facilities, use of operating theatres and outcomes in A&E, cancer and colorectal surgery.

However, it remains unclear whether Circle can achieve the challenging savings or growth needed to secure long term sustainability.

Case study

The governance structure at Hinchingbrooke allows Circle sufficient representation and accountability while retaining the legal minimum for an NHS Trust

Trust Board	• Statutory minimum composition consisting of three Non-Executive Directors, one of whom is the Trust Chair. • Trust Board is responsible to the Secretary of State, via the NHS Trust Development Authority, for the performance management and monitoring of the franchise and 'reserved matters' set out in the Franchise Agreement. • On a day to day basis this responsibility is undertaken by a Franchise Manager. The reserved matters include the public accountability function of the Trust. The Trust Board is also responsible for the approval of the statutory accounts.
Franchise Manager	• Appointed by the former NHS Midlands and East Strategic Health Authority (SHA) to operationalise the franchise contract on behalf of the wider NHS. Holds responsibility for the performance management and monitoring of the Franchise Agreement on behalf of the Trust Board to ensure that Circle meets its obligations under the Franchise Agreement. • The Franchise Manager is not part of the formal governance chain at HHC.
Trust Chief Exec	• The HHCT Chief Executive is the Accountable Officer for the hospital and is responsible for all day-to-day operations of the hospital, with the Executive team and hospital staff.
Executive Board	• Executive Board is responsible for the day to day running of the Trust as well as setting the strategic direction and managing external communications with stakeholders. • 15 members: 11 clinical and 4 others.

Case study

Ribera Salud, Valencia

Set up	• Ribera Salud Grupo was established in 1997 to design, build and operate a new hospital in La Ribera, Valencia Community under a public-private partnership (PPP). • The Ribera Hospital was the first privately run public hospital in Spain, expanding into primary health services shortly afterwards to strengthen integrated provision following initial strong performance. • Ribera Salud financed and built the site, which returned to public ownership after 15 years. They now pay rent to the government for its use (or can reduce protected population and hence income).
Operation	• The form has since expanded across Valencia and in other regions in Spain: 4% of the Spanish population is now treated under PPP forms, and 20% of Valencia's population. • Ribera Salud operates the concession under contract with the government, which holds them to account – through a commissioner – for quality standards and outcomes. • Ribera Salud assumes the risk for demand and outcomes over the 15 year duration of the contract (extendable to 20 years).
Partnership	• Each hospital is a separate company, with Ribera Salud the majority shareholder in two of these. There are separate governance and accountability structures in each hospital. • Requires a new approach of partnership and a long term perspective. There is no short term profit or savings to be made, and a 7.5% cap on return requires a shift in corporate mentality. • No company logos – only the national health service branding as in any other public hospital. 94% of patients do not know the hospital is PPP operated.

Key considerations

What are the scenarios in which the form could apply?

The key aspect of the form is that it is an asset light way of allowing alternative providers to deliver services to a population, ordinarily using existing estate and facilities. It is possible to build an entirely new site for which a management partner will subsequently be identified, but this is unlikely to be relevant in the NHS context – at least in the short to medium terms. There are therefore no specific scenarios which a management contract or operational franchise are or are not applicable.

However, there are two key points which limit the scenarios which management contracts or franchises apply:

- the contract will cover defined services which are required to meet the needs of the local population.
- the need for the contract to limit significant service changes.

The combined effect is that the form is only applicable in scenarios where the existing estate and defined bundle of services is fundamentally sustainable; where there are wider issues meaning the site will never be financially viable in its current form, unless specifically allowed by the contract the contractual constraints will not allow for significant enough change to alter this.

Management contracts are therefore most appropriate in cases where a provider is struggling to deliver sustainable and quality services but that these could be overcome with sufficient management expertise and possibly some economies of scale (i.e. back office functions).

- Some organisations holding management contracts are redefining the scope of their services, in part due to challenges managing whole organisations without full delegated authority.
- For example, HCA have now formed new company (Parallon) which provides more targeted management functions rather than whole hospital management.

Key considerations

Does the form apply across some or all geographical circumstances?

Much like multi-service chains, management contracts could potentially operate across all geographical circumstances through their ability to support individual sites through standardised processes and unified back office and support functions.

Depending on the managing organisation and the extent of the infrastructure they are able to offer the Trust, it may be possible for organisations under external management to operate sustainably in situations that would be unsuitable for some types of standalone organisations i.e. where the combination of shared services, centralised procurement and management expertise is sufficient to overcome sustainability issues faced due to rural location or isolation. However, if resource sharing is key to the success of the form this is likely to be geographically limiting.

The experience of the USA suggests that characteristics of each site will determine whether a management contract is appropriate, and if so, what type of organisation is most suitable to provide the management e.g. issues of isolation or small size may require recruitment and retention expertise or of raising capital; larger urban sites may require regulatory and competition expertise.

Key considerations

Does the form apply across different health economies?

In hospital systems with a greater share of private insurance or out of pocket expenditure, there can be significant pricing differences between hospitals/providers. These are partly based on ability to negotiate higher prices for particularly high clinically performing hospitals. Organisations providing management services are therefore potentially able to generate higher income per patient when improving outcomes. The early experience from the USA showed that hospitals under contract raised prices compared to pre contract management periods, due to more successful pricing and reimbursement activities.

Under NHS Tariff this is not possible, so that removes a significant lever for the managing organisation to improve financial sustainability of the hospital under management (and therefore their payments for managing). Commissioners can agree above tariff rates for providers but this would not ordinarily be based on purely commercial negotiations as in the US context. This means it is both more difficult for the managing organisations to make the required improvements in financial sustainability and reduces the incentives to take on contracts in the first place without more generous non-performance based payment plans.

The organisation under management must therefore be in a health economy with sufficient patient flows and population composition to allow for the required income under the NHS tariff to be – in principle – financially sustainable and to allow the managing organisation to receive a suitable fee.

Key considerations

Does the archetype apply to a single service, a limited range or full multi-service organisations?

This archetype primarily applies to multi-service organisations that operate all or most of the services and specialties delivered on each site that it owns. Service-level chains, which operate a single specialty or service on a satellite basis at sites owned by a host organisation, are explored separately.

The primary source of value in management contracts is being able to improve quality and operational efficiency in another organisation by deploying the proven operating frameworks, procedures and policies developed on existing sites.

This means the applicability of the form is likely to depend on whether the operating company has the specific capabilities, expertise and structure required to make significant improvements in the services provided by the body under management. This could entail management of an entire organisation or elements within this.

Key considerations

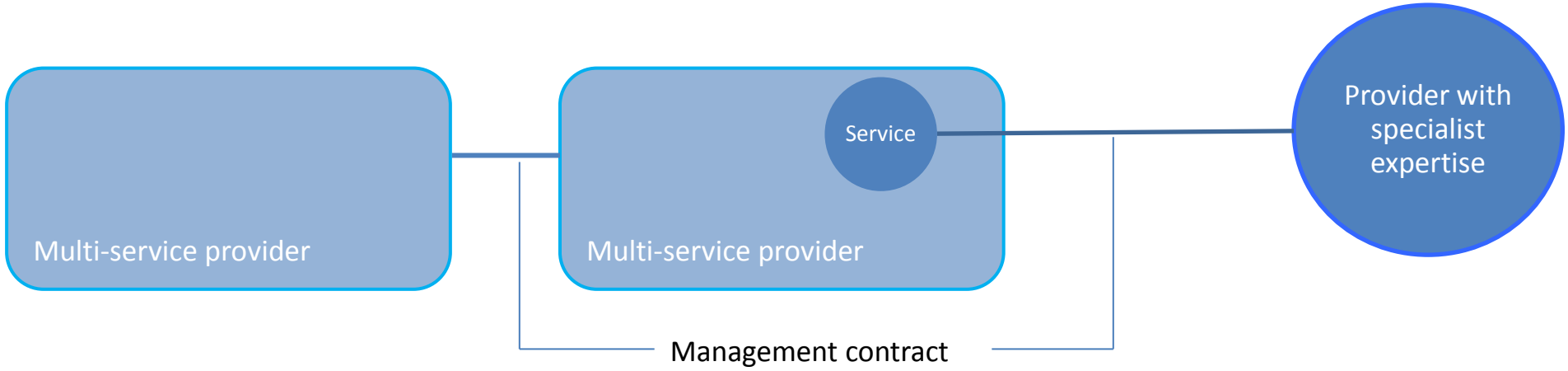
Does the organisational form interact with others or is it a stand-alone form?

Management contracts and franchises align readily with other forms and may provide a mechanism for their adoption.

This can encompass the whole organisation scale or single service level:

- Ribero Salud Grupo operates Accountable Care Organisations under management contract.
- Specialist providers may operate a service level chain through management contracts.

Organisations under external management are unlikely to enter into tight federations, as being in this form means they will have already captured many of the relevant benefits, however loose federations to support the coordination of academic research or clinical improvement may offer benefits.



Key considerations

What is the role of organisational leadership in the form?

Managed organisation

Hospitals may initiate the search for an acquiring organisation themselves, or where directed to do so by governors or an external body such as a regulator.

The Trust Board for the site must divest of direct operational management, appoint an external organisation to undertake that role and shift their focus to overseeing and managing the performance of the contractor organisation.

The relationship between the remaining Board members in the managed organisation and the contractor will be crucial to the success of the endeavour – it is important that they engage in constructive and collaborative dialogue.

Contractor side

The process of taking over management of another organisation requires significant investment in time and energy to integrate the management practices and pathways.

This will include embedding standardised operating frameworks, procedures and policies, appointing the executive committee for the newly acquired site and removing surplus capacity. Distance between sites and/or headquarters may make this process more difficult, as would resistance from the host Board.

Key considerations

Are the motivations to develop the form primarily defensive or strategic?

	Defensive motivations	Strategic motivations
Host	• To stabilise and improve clinical performance in struggling organisations. • To address issues of management capacity or expertise e.g. cost control, recruitment and retention.	• Gain additional management capacity to improve performance overall or while management time is diverted by e.g. expansion. • To focus on key objectives / areas, and delegate some functions to management partner. • Provide safer services and better outcomes for patients.
Outreach	• Increased income to spread cost base more widely. • Provide income to fund required investment at host site. • Mitigate challenging referral patterns, where both organisations are in close geographical area.	• Gain experience running geographically disparate organisations, potentially before forming chain structure. • Build depth and breadth of management experience. • Increase income to fund service investment. • To improve wider health service sustainability.

Key considerations

Are the barriers to the form primarily technical, strategic or a mix of both?

	Technical barriers	Strategic barriers
Host	• Need for clarity on reporting lines, accountability, patient liability and performance management. • Need to ensure staff are aware of any implications on their roles or Ts&Cs. • In an FT ensuring that the role of the Council of Governors is clear.	• Perception that management contracts suggest a failure at the host organisation. • Strategic direction of the organisation may be perceived to be compromised if operational and management control is ceded to another organisation.
Outreach	• Need for clarity on reporting lines, accountability, patient liability and performance management. • May need to use unfamiliar IT and information systems. • Diversion of management time. • Challenges operating over wide geography. • Host organisation may not delegate sufficient control to the management partner.	• Understanding of the host organisation and the local health economy – there may be practical difficulties that only become apparent some time into the contract. • Local resistance; local staff and other healthcare providers may be concerned over the impact of an external healthcare provider. • Reputational risk if sufficient improvements cannot be made.

Key considerations

What support and incentives might be helpful to further the spread of the form?

- Management contracts are a relatively untested form in the English NHS, and as such there is limited experience and expertise in drafting and managing this type of contract. Guidance and support in setting up contracts for relevant NHS professionals and regulators would be helpful in providing a wider range of options for decision makers.
- Further to the above, national level standardised documentation and terms for management contracts could be helpful to allow competitive and clear procurement processes; where the offer and process is broadly the same for each option interested parties can most easily consider whether they are interested in offering management support. This also allows a fair and open competitive process, so the most appropriate partner can be selected in each case.
- There is uneven awareness of the potential benefits and circumstances the form applies to across the NHS. There is a perception that it only applies in challenged organisations or involves loss of full autonomy. Increasing the system wide understanding of the wide applicability of the form and benefits this can bring would allow management contracts to be more effectively considered as part of the strategic tool kit for organisations.
- Building on the above, wider availability of brokerage and support in identifying host organisations in demand of services would facilitate the spread as appropriate to each local circumstance i.e. back office support or whole organisational capacity building.
- Encouragement for high performing Foundation Trusts to see the benefit of entering into management contract arrangements and that this is not just an option for the independent sector.
- The implications for the Trust Board of the outreach Foundation Trust taking on a management contract including the personal accountability under the 'fit and proper persons test' will need to be clarified.
- For Foundation Trusts that are going to be in receipt of a management contract, the role of the retained Council of Governors will need clarification.

Department of Health

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