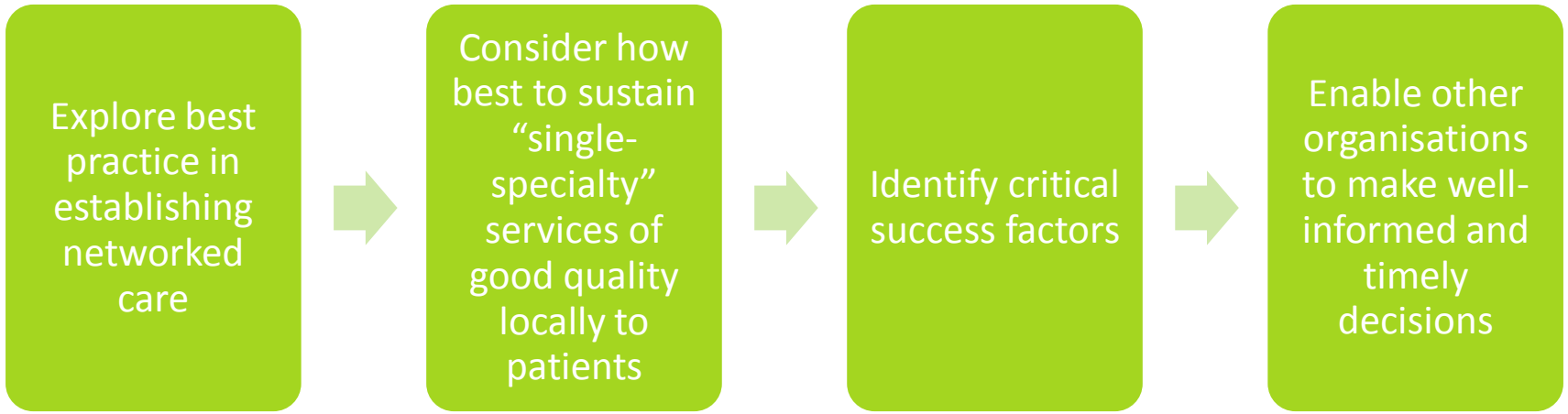
UCLPartners
Academic Health Science Partnership

Moorfields vanguard programme

Board-level enquiry: non-networked care providers

Aims of the project



Methods

- **Semi-structured interviews with 13 stakeholders**

- **Including:**
  - chief executives, medical directors, finance directors, directors of strategy/business/partnership, chief nurses, clinical directors
  - 6 trusts represented from a variety of geographical contexts
  - additional 4 interviews from Andrew Liles, Concilium

- **Analysis**
  - Open-ended categorisation of data
  - Detailed coding of verbatim transcripts
  - Comparisons

Main findings

Why do people anticipate using a networked model?

- When they have low volumes
- When they have problems with quality
- If they couldn’t provide a full rota
- In order to save money

Chief executive

if you've got problems in terms of if your mortality rates were particularly high for that service and you did a drill down to try and understand what the reasons were for that, that might make you think about doing something very different about that service

What would be expected of the model? Quality of Care

- Maintenance of clinical quality is expected to **stay the same or improve**
- Patient experience is expected to be **high**
- Clinical governance is expected to be **transparent**
- **Standardisation** of the service
- Better **range** of services

Medical director

You would hope that there was better governance and scrutiny and processes and pathways. Yes, and networked, it might also mean that you can offer some specialties within that as well. Ophthalmology is a good example where ophthalmologists all do a different, sounds really stupid, always different part of the eye for instance. So actually you could, if you've got that wider cover, you could also have a better range of services at each site.

What would be expected of the model? Finance and resources

- Dominant market share
- Reduction in **overhead costs**
- Avoid making a loss unless strategic
- Share some costs to the trust

I suppose I'd be concerned if I was actually being asked to provide a large expensive piece of equipment and then would have concerns that the lifetime of the equipment might exceed the lifetime of the arrangement.

Finance director

Now some of them spend longer out of the organisation than they do in but are employed by us. And so we pick up the extra bit of a consultant's job plan, which is around the time they need to keep up to date and do their *manager* training and teaching and appraisal and all these other things. So there is a cost associated. If one employer gets more of the cost and so on that very granular level, that's something that might be considered shared across if you're employed by a network rather than an organisation.

Medical director

What are the concerns? Operational performance

- Workforce issues, particularly **consultant posts**, and cover
- Questions around who would be responsible for targets and incidents
- Priority to partner site

If there's a pressure in the [host] site, are staff going to get pulled back in there or if there's pressure at some of the other locations are we going to ensure that we have the same priority for our services as we do if we're running a service ourselves?

Chief executive

So, for example, if you're in a network, where would the PTL sits, where or who would be having oversight on meeting the target, things like two weeks' wait for cancer, that sort of target that we have to meet. If you're in a network arrangement where would that exactly sit, as well as the clinical governance around it, reviewing of incident, reviewing of performance, responding to complaint, where does it actually sit.

Clinical director

What are the concerns? Strategic development

- Relationships with the networked trust expected to be difficult to manage
- Long-term impact on existing services a source of anxiety

My experience is that we need a routine joint management board or steering board to oversee any kind of networked care because you are all good friends at the beginning when you sign up to the service, but everyone becomes complacent after a while, and you only get together with a provider when something goes wrong, often something hasn't been covered by the SLA

Medical director

I think there is something about the natural joint working between the trusts, because in order to make these things work you do need a bit of give and take, it's impossible to try and come up with a, with an arrangement that works equitably for everybody in all circumstances from a financial perspective.

Finance director

What are the concerns? Leadership and development

- Role of the board is unclear – jointly run or existing board maintained
- Governance mechanisms need to be powerful to give confidence
- Not clear who would have oversight of quality at a specialty level
- Clarity around penalties/performance

Medical director

I would presume if there was a networked service that you would have very tightly written operating procedure and policy to cover that off. But yes, you would have to, there would have to be clear lines of accountability, wouldn't there?

What do we think potential network providers should know?

Explaining the service

- Patient understanding of the service expected to be low
- Providers looking at many different shared models
- Specificity of the model shown to be poorly understood

Trade offs

- Demonstrable quality considered more important than financial viability

Risks to potential network provider

- Many sites would only consider model if they were failing
- Extra governance burden
- Each site would want ‘bespoke’ solution