Diagnostic imaging network commercial structure and operational governance guide

April 2021

Guidance developed in consultation with The Royal College of Radiologists, Society of Radiographers and Institute of Physics & Engineering in Medicine.

Contents

1. Introduction

About 151 NHS trusts and foundation trusts provide their own imaging services, using operating models that need investment in premises, IT and equipment. Providers are also competing for increasingly scarce medical and non-medical staff.

To address these challenges, The NHS Long Term Plan committed the NHS to have established imaging networks across England by 2023; later our national imaging strategy outlined how their formation will maximise use of existing capacity, improve access to specialist opinion and make efficiencies and economies of scale. This strategy is backed by NHS evidence that networked imaging services and the modernisation that goes with this increase both quality of service for patients and efficiency, and make these services more resilient and sustainable.

We are now looking to up the ambition and accelerate the transformation of imaging services across the NHS. The national imaging strategy proposes transformation by introducing an image-sharing platform whereby all digital images acquired within the network can be managed via a single shared worklist and transferred for reporting to any site in the network, or beyond. Networking enables imaging services to maximise the benefits of pooling the reporting workforce by making economies of scale and improving access to specialist opinion, while individual sites continue to image patients close where they live.

The diagnostic imaging model has inherent challenges for trusts, including the formation of the desired operating model and the governance to control it. Also, these changes need to be delivered at a time of constraints on capital and internal resources.

1.1. Purpose

This document explains the options available to trusts transforming their imaging services for the commercial structure of the diagnostic imaging network, and gives guidance on the operational governance structure. It has been reviewed and approved by the National Imaging Optimisation Delivery Board which has broad representation from imaging services, including the Royal College of Radiologists, the Society and College of Radiographers, the Institute of Physics and Engineering in Medicine, and the imaging industry.

Clinical governance and outsourcing commercial structure, while acknowledged in this guide, will be covered in more detail in further guidance to be published in due course.

This guidance has been informed by imaging services management experience and expertise, a review of several case studies from diagnostic imaging networks and input from trust executives who have been through the experience of establishing a network, both successfully and unsuccessfully.

We will update this guidance regularly to reflect new information regarding commercial and governance structures in the context of developing networked imaging services.

1.2. Disclaimer

We provide guidance only and you should seek further specialist advice regarding the formation of commercial structures and governance policies.

1.3. Useful further reading

- Care Quality Commission new provider registration information
- UKAS application process
- *The 2017 good governance report: the great governance debate continued*.

2. Why is organisation structure important?

Imaging networks are collaborations between multiple NHS provider organisations, and their scale is such that they are significant operating businesses in their own right. To ensure that these partnerships are enduring and successful, a clear structure for both ownership and operation of the imaging network is essential.

Once the NHS provider boards of the member organisations have given a commitment to form an imaging network, and there is a mandate to proceed from each trust chief executive, a new identity and operating model are important because:

- the trusts' imaging operations are being transformed under a seamless management and governance structure
- operationally the new diagnostic imaging network will serve all the trusts equally in providing first class imaging services and as such needs a distinct identity and arm's length separation from the trusts
- staff are more likely to be equally and significantly engaged (in a challenging transformation) if they can identify a common loyalty to a new 'brand' and an operational management structure distinct from existing arrangements in their individual trusts
- the diagnostic imaging network will require a degree of operational flexibility to set and execute its own priorities; it is unlikely to have this as part of the trusts' divisions
- the diagnostic imaging network will be required to operate with a degree of autonomy over governance arrangements in accordance with the standing orders and scheme of delegation of the host trust
- if established as a separate legal entity, according to Care Quality Commission (CQC) guidelines, CQC must nominate and approve accountable persons and new entities must be registered
- roles and responsibilities need to be clearly separated. There should be a clear unified specification to drive a single service offering rather than a bespoke offering.

Evidence from other clinical network programmes in the NHS demonstrates that establishing clear formal structures at an early stage of network development is a key determinant of quicker progress toward network maturity, and better outcomes.

This guidance refers to the different forms of ownership structures collectively as the ‘commercial’ structure. This is a technical term and should not be misconstrued as encouragement to privatise NHS imaging services.

3. Structure

The new diagnostic imaging network must define its commercial structure to have its own identity and operating flexibility. This will be distinct from how each NHS secondary healthcare provider's existing divisional management structure manages imaging services.

To be accredited against the Quality Standard for Imaging by the United Kingdom Accreditation Service (UKAS), an organisation must be a defined legal entity. In the context of a network, accreditation could be held, for example, by the host NHS foundation trust or trust, or by a new legal entity created to run a network (such as by a joint venture). The legal entity does not need to supply all aspects of the imaging services but it does need a clear contractual relationship between the host secondary care provider and any sub-contractors.

Below we give some examples of the types of commercial structure that a new diagnostic imaging network could adopt to underpin the implementation of a target operating model. These are the options that support autonomous operation. They are:

- collaboration across two or more organisations with a single operational management team (most suitable for the distributed network model)
- alliance contracting
- unit organisation hosted by one NHS secondary healthcare provider (suitable where the partners looking to collaborate are all NHS parties)
- joint venture – limited liability partnership (LLP)
- joint venture – limited company (by shares or guarantee)
- community interest company (CIC)
- outsourcing.

3.1. Collaboration across two or more organisations with a single operational management team

This structure is only suitable if all parties are providers of NHS secondary healthcare services and does not involve the creation of a new legal entity. Under this approach,

the parties enter an agreement to collaborate in, and jointly manage, the delivery of imaging services. Staff would remain employed by each trust and the imaging management team would report to all trust boards. Investments or changes in the operations must be approved through the normal mechanisms of each trust. While the operational management of the service may be joint, it would be overseen by each of the trust's boards and these would remain accountable for decisions about the service. Under this option all trusts retain full responsibility for their ancillary services relevant to imaging (such as provision of finance, HR, back office support). Imaging services at each trust are largely independent of each other, although the joint management team will look to standardise operations across sites. Each member trust is responsible for its own quality accreditation, but the creation of a joint quality oversight body is highly recommended to ensure good governance.

3.2. Alliance contracting

Alliance contracting is a variation to the option under Section 3.1 above and similar to an informal joint venture, but it is only suitable when all the NHS providers are NHS bodies. No new legal entity is created and instead the NHS secondary healthcare providers work together on aspects of the service, with individual NHS secondary healthcare providers taking the lead for certain aspects.

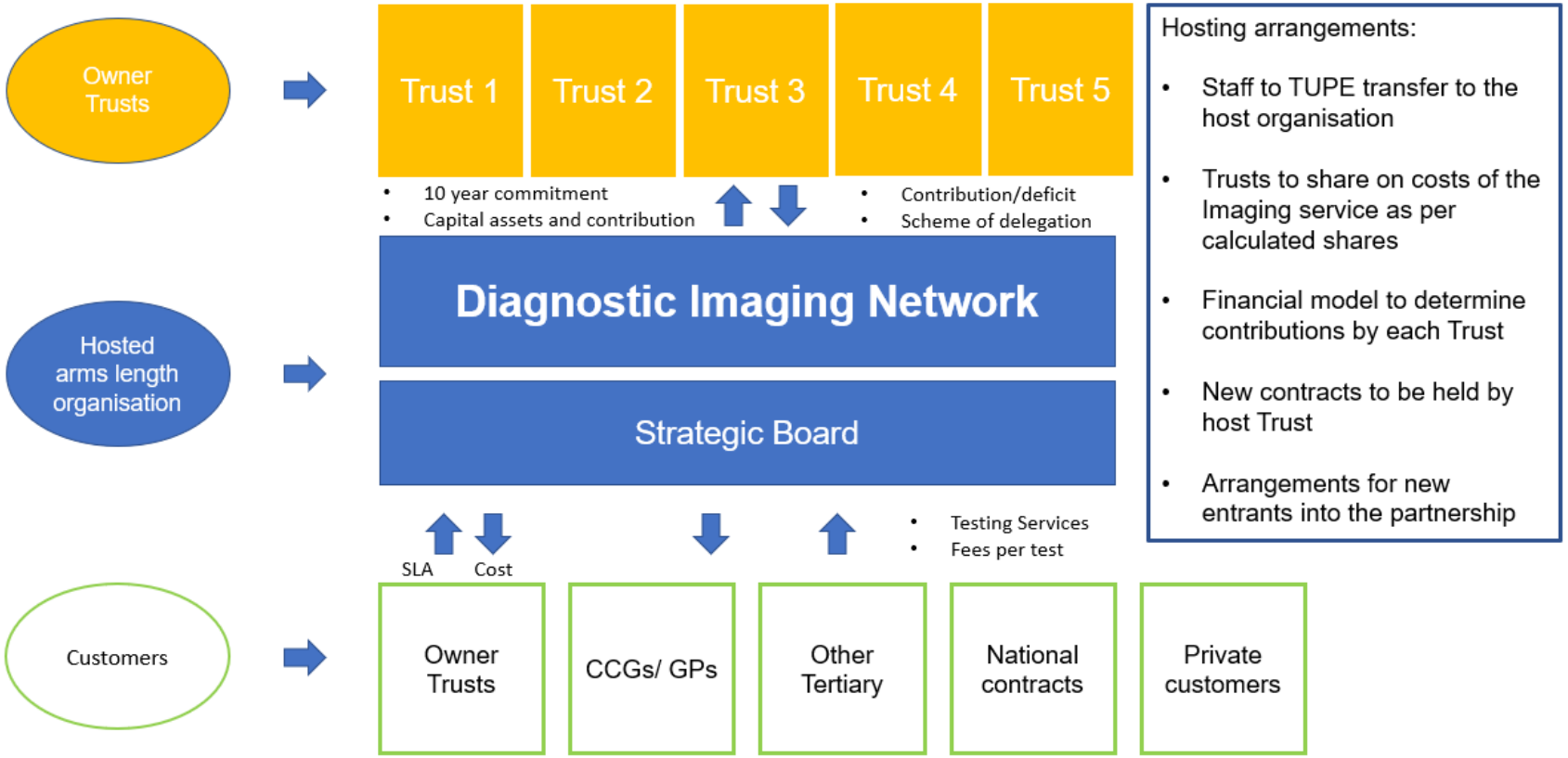
One example is alliance contracting for certain areas of the imaging service. For example, one trust may take the lead for IT and as such the contracting of this aspect on behalf of all the trusts; and another trust lead for equipment. So, certain aspects of contracting or control are transferred informally between parties, but most of the delivery and contracting of ancillary services remains with each NHS secondary healthcare provider.

Another example is all providers retaining their commissioning contract with the clinical commissioning group (CCG) but also entering into an alliance agreement setting out how they will co-operate with each other. For example, NHS secondary healthcare providers within the network will collaborate to collectively deliver image reporting for all patient activity, irrespective of which CCG has commissioned the activity. The alliance agreement therefore sits over existing commissioning contracts and must set out shared objectives and principles, and shared governance; there may also be gain/loss share arrangements. Each member trust is responsible for its own quality accreditation.

3.3. Unit organisation hosted by one trust

This commercial structure is a variation of the option under Section 3.2. It is only suitable where all parties are NHS bodies and does not involve the creation of a new legal entity. It involves the full integration of all imaging services to create a unit organisation hosted by one of the trusts but serving all trusts in the joint venture. This may involve the transfer of some staff from the non-host trusts to the host trust under Transfer of Undertakings (Protection of Employment) regulations (TUPE). All contracts, finance systems, liabilities and responsibilities are transferred to the host trust and shared through the joint venture agreement. It is worth noting that some commissioning contracts could remain with the original NHS secondary healthcare providers and be novated to the host trust of the contractual joint venture at a later point; or at the recommissioning of this work the joint venture could tender through the host trust acting as lead (subject to the terms of the commissioning contracts or competition thereof by the relevant NHS commissioner(s)). The joint venture cannot enter into long-term contracts or raise capital other than through the normal channels of the host trust.

This structure allows for a responsive service that is well-defined commercially and where the operational management team has full control of operations at all sites. This means it has greater leverage to optimise the efficiency of the service and implement change. Each trust retains clinical control through the clinical governance structure which is managed by the clinical committee with representatives from all member trusts. Equally, a level of operational control is retained by all trusts through the consolidated network management board (committee in common) where all trusts have representatives and voting rights. The operational management teams can only implement changes in accordance with a well-defined scheme of delegation.



SLA, service-level agreement.

3.4. Joint venture (thick or thin) – limited liability partnership

A **thick joint venture** is where the legal entity actually employs all the staff and takes ownership of all liabilities. In a **thin joint venture**, the legal entity would provide strategic guidance and hold customer contracts, with all or defined risks passed onto a sub-contractor. Creation of an LLP may require regulatory approval by NHS Improvement and reference should be made to the relevant transactions guidance.

An LLP is a corporate body with a separate legal personality similar to that of a company (although it is not a company). It would be suitable for the purposes of a joint venture only where the parties to the joint venture are NHS foundation trusts. Unlike in a normal partnership, the members of an LLP enjoy limited liability, as the name suggests – liability is limited to the amount of money each trust invests in the business and to any guarantees the trusts give to raise finance. LLPs are allowed to raise finance. NHS trusts would not be able to participate in the formation of a joint venture of this nature, but could enter into a contractual arrangement with such a joint venture formed by a network of NHS foundation trusts.

3.5. Joint venture (thick or thin) – limited company by shares or guarantee

This is the most common organisational structure for setting up businesses. It would only be suitable where the parties to the joint venture are NHS foundation trusts. The incorporated organisation will have a memorandum (describing the members setting up the organisation) and articles of association (describing how the company is to be run and any benefits shared). Liability is limited to the assets of the company and not the individual finances of the shareholders. Under this structure the joint venture can raise capital and enter into long-term contracts.

3.6. Community interest company

A CIC is a form of company (limited either by shares or by guarantee) created for so-called ‘social enterprises’ that want to use their profits and assets for community benefit. CICs are easy to set up and have all the flexibility and certainty of the company form, but with the following special features that ensure they serve a community interest:

- the company must submit a community interest statement
- the company must have an ‘asset lock’ (all assets are for the benefit of the community)
- caps on how profits are distributed and the level of reinvestment required.

As with other company forms, it would only be suitable where the parties forming the CIC are NHS foundation trusts.

3.7. Outsourcing

A trust or network of trusts can contract the imaging services and operations through a tender process to a third party which is empowered to provide such services and become a customer of an imaging service. Under this model, the third party becomes a sub-contractor of the original trust or network of trusts in connection with the relevant healthcare service commissioning contract between that trust or network of trusts and the relevant NHS commissioner. This option has advantages including access to economies of scale, and disadvantages including the loss of direct control of operations.

3.8. Summary of commercial structures

Commercial structures	Raise capital	Feasibility	Autonomy of operation	VAT
Collaboration	Each trust is responsible for raising the capital required or contracting with an organisation to supply capital	Highly feasible (common across the country) – though dependent on organisational form chosen	Poor autonomy as all decisions are subject to approval by all trusts, including clinical governance	As per current NHS rules
Alliance contracting	Each trust is responsible for raising the capital required or contracting with an organisation to supply capital	Requires common agreement between the trusts, commitment and trust	Poor autonomy as all decisions are subject to approval by all trusts, including clinical governance	As per current NHS rules
Unit organisation within host trust	Host trust is responsible for raising capital or contracting as above	Possible if one trust agrees to host – clear operational and clinical governance structures to be set up	Almost full autonomy as imaging operates as a division of the host trust under a delegated authority scheme	As per current NHS rules
Joint venture – LLP	Commercially or through partners as per partnership agreement	Only suitable for NHS foundation trusts	Full autonomy	HMRC approval
Joint venture – limited liability company	Commercially or through partners as per articles of association	Only suitable for NHS foundation trusts	Full autonomy	HMRC approval

Commercial structures	Raise capital	Feasibility	Autonomy of operation	VAT
CIC	Commercially or through partners as per articles of association	Possible as there is precedent in the UK, although only suitable for NHS foundation trusts	Full autonomy although activities and reinvestment by the CIC principles are limited	HMRC approval
Outsourcing	Each trust is responsible for raising the capital required or contracting with an organisation to supply capital	Highly feasible (common across the country)	Autonomy over the contract outsourcing arrangements and key performance indicators (KPIs)	As per current NHS rules

4. Key considerations

This section describes the key commercial terms that need to be discussed and agreed during the development of an outline business case (OBC) under the options set out in Sections 3.4 to 3.6 above.

4.1. Ownership and calculation of ownership shares

The ownership stake on the liabilities and benefits the partnership might create need to be agreed early, including how they are calculated.

In an LLP the formation agreement should define how liabilities, benefits and capital investments should be apportioned by the contracting parties as there are no ownership shares.

The proposed methodology for calculating the respective ownership shares of a partnership between trusts applies to all the commercial models for the formation of a company.

The underlying rationale for the methodology is to identify and value the contributions of each organisation to a joint venture at the time it is established. Value can be defined as contribution forgone for work transferred into a joint venture or via the exclusive use of key assets, be they staff or equipment.

Value is not intended to be attributed to services used on an arm's length basis – for example, the renting of space from a trust, as this obligation – the payment of rent – will pass to a joint venture at the time of its establishment.

Below we set out the proposed contributions from each trust that are the basis for valuing the ownership shares.

Contribution	Description	Valuation method
Existing activity	Each trust will contribute its existing activity to the new entity, under a contractual agreement Trusts will retain external contracts (if permitted under those contracts), including GP direct access work, and will be charged by the new entity for the delivery of the work	Existing organisations' activity that will be provided by the new entity will be valued against an agreed common test price list for all organisations This activity will be contributed to the joint venture with potential margin retained by the organisations
Key imaging delivery staff	Each trust will contribute key clinical and scientific staff to the new entity	Agree the level of posts/individuals jointly with each trust's clinical lead and value them at their current full-year cost
Key executive management staff	Value the contribution of existing senior managers (director level) from the organisations to both the creation of the new entity and then as part of the executive team operating the new service	Two elements to valuing this contribution: • agree with the finance leads of the project who the key executive staff have been and their contribution to establishing the new entity • value the appointments to the new entity executive management team from each trust
Land or other assets	If any organisation contributes, for no cash consideration, any land or other asset for the exclusive use of the new entity, this will be valued and attributed to the respective trust	Any land or other asset made available in this way will be valued at its existing book value
Capital investment	If any organisation agrees to a capital investment as part of the formation of a new entity, this will be attributed to the respective organisation This also includes any planned capital expenditure within the predicted lifespan of the new entity as agreed by all parties at its formation	Any initial investment will be valued at the current cost Future capital investment will be discounted by an agreed rate, taking into account the relevant inflation rate and cost of capital

Contribution	Description	Valuation method
Imaging equipment	Any imaging equipment that is required by the new entity and will be made exclusively available to the new organisation will be valued	An initial estimate is based on the entire inventory (asset register) value of imaging equipment held by each organisation This valuation is then refined once the final equipment requirements of the new imaging entity are agreed
IT equipment	As above but for IT equipment	As above
Working capital	Any agreed initial start-up working capital to fund the new entity by the organisation will be valued and attributed to that organisation	This will be determined when the detailed three-year operating plan is developed by the new entity, and agreed by all organisations
Stranded costs	An organisation may have a stranded cost as a result of changes to the configuration of imaging services This will be considered as part of the valuation exercise given that the organisation will be taking on a liability in establishing the new entity Stranded costs will be agreed with all organisations before the new entity is formed	Proposed that stranded costs will be valued at the cost for the 12 months following when they become redundant; this will give the respective organisation the time to re-deploy, re-use or remove

5. Governance

Project governance refers to the rules and procedures under which a project functions. It is frequently used to describe the processes necessary for a project to succeed. Project governance outlines the relationships between all stakeholders involved in the project. It describes the flow of project information to all stakeholders and ensures reviews and approvals at appropriate stages of the project. Project governance not only provides a framework for the organisation of responsibilities and decision-making capabilities, but also ensures that the project is smoothly implemented and executed.

The key aims of project governance are to:

- set out the lines of responsibility and accountability for the delivery of the project
- give stakeholders responsibility for managing their interest in the project
- support the project team in delivering the required outcomes by providing resources, giving direction and enabling trade-offs and timely decision-making
- provide a forum for issue resolution
- ensure equality impact assessments are completed at the relevant stages
- provide access to best practice and independent expert advice
- disseminate information through regular reporting to stakeholders, so that they can fulfil their roles effectively
- manage risk.

The following governance structures are generally applicable to all the commercial structures outlined in Section 3 with the exception of outsourcing.

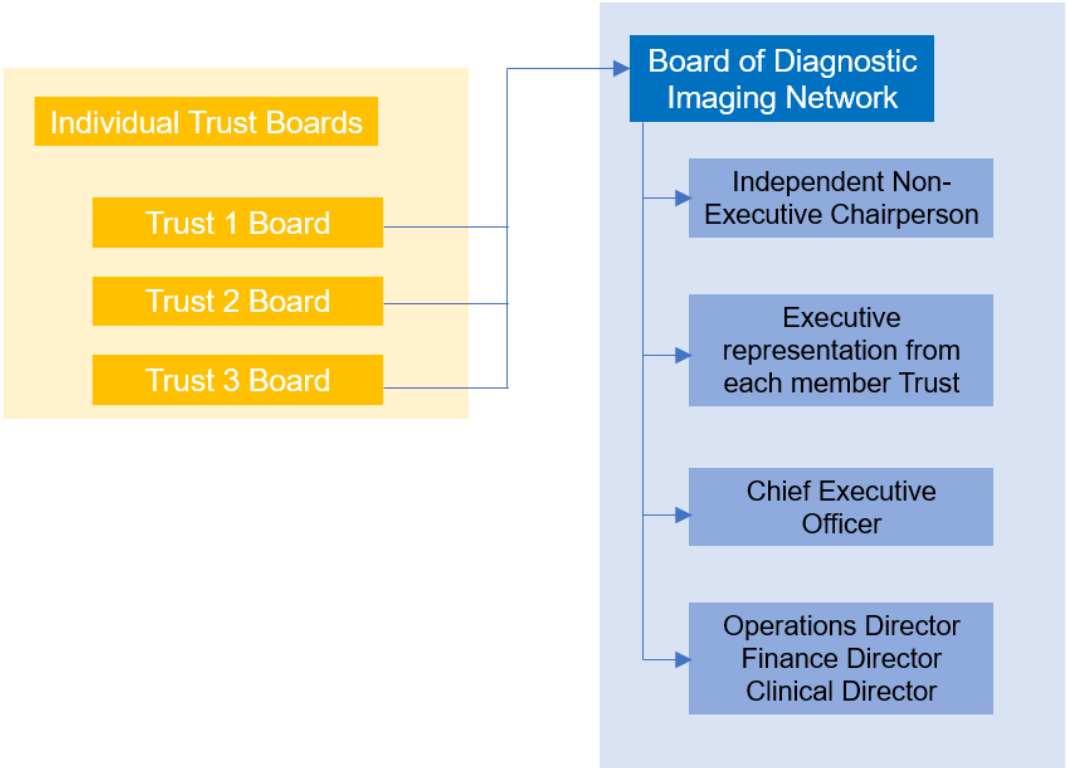
5.1. Executive governance

The new imaging operation should establish a partnership board with executive representation from each member trust. Each trust should be represented by a clinical director and either a financial or operational director.

The board should be chaired by an independent non-executive appointee and meet regularly to allow agile decision-making, support timely progress and dispute resolutions. The board will hold overall accountability for the performance of the new imaging operation, including governance, strategy, clinical viability, financial viability and quality.

Along with trust executive representation, the board should appoint a chief executive to the new imaging consolidated network to ensure there is a single point of responsibility for delivery. The board should also have clinical, financial and operational representation from the new imaging operation.

Where the board representatives have both an ownership and customer relationship with the joint venture, non-executive board members should be appointed to provide effective challenge to the board. An alternative is a mechanism that focuses the board members on their role as directors of the joint venture rather than service users.



5.2. Clinical governance

While clinical governance is outside the scope of this guide, we recommend a clinical steering group is established, consisting of the clinical users of the service, and feeds into the board of the diagnostic imaging network. One of the trust representatives from the diagnostic imaging network's board should be its chair.

Initial considerations will focus on the board's role and composition, such as:

- representation on board
- creation of an executive and non-executive team
- management of a large business and staff responsible for finance, operational, commercial and clinical initiatives
- a mechanism for transparently and effectively reporting performance (this is required because of the size of the business)
- appointment of immediate and future board members (internal and external)
- appointment of chair
- appointment process for independent members
- organisational form and model that best fits the collaborative principles agreed by the trust partners.

5.3. Other key commercial terms

Other key commercial terms that the executive board may like to consider are listed below with reference to partnership models, corporate models and outsourcing arrangements, as may be applicable.

Key term	Description and issues	Outsourced option (option 3.7)	Host/alliance options (options 3.1 to 3.3)	Joint venture and partnership options (options 3.4 to 3.6)
Ownership shares	A methodology based on the 'value' of each trust's contributions to the new entity will be defined and agreed	As the trust will outsource the management and delivery of the imaging services, the sub-contracted party will be responsible to the trust for providing those services under the terms of the sub-contract. However, the trust will remain responsible to their NHS commissioner in respect of providing those services as prime contractor under the terms of their NHS healthcare commissioning contract and the NHS commissioner would have to allow the sub-contracting	Contribution method, cost base method and volume/revenue method. All of these can be tailored to accommodate local needs and changes	Contribution method, cost base method and volume/revenue method. All of these can be tailored to accommodate local needs and changes
Exit arrangements	A methodology for the potential exit of an organisation	Break clauses will be determined in the contract with the outsourced provider and will be subject to negotiation It is critical that the trust retains an ability to exit the contract if the outsourced provider repeatedly does not meet the KPIs in the contract	If any owner organisation wishes to terminate its customer contract with the collaboration it should give the network a defined period of notice, and this should be set as the minimum in the initial service agreement between the network and the owner trusts as 'customers'. A 12-month notice period would be appropriate. If the termination is before the full required notice period then the	If any organisation wishes to terminate its customer contract with the joint venture it should give the joint venture a defined period of notice, and this should be set as the minimum in the initial service agreement between the LLP or limited company (LTD) and the owner trusts as 'customers'. A 12-month notice period would be appropriate.

Key term	Description and issues	Outsourced option (option 3.7)	Host/alliance options (options 3.1 to 3.3)	Joint venture and partnership options (options 3.4 to 3.6)
			terminating organisation may be responsible for any additional costs incurred by the network for the notice period following the termination. This should be defined in the original service agreement between the network and the owner trusts as 'customers'.	If the termination is before the full required notice period then the terminating organisation may be responsible for any additional costs incurred by the joint venture for the notice period following the termination. This should be defined in the original service agreement between the LLP or LTD and the owner trusts as 'customers'.
Intellectual property (IP)	A methodology for use of the organisations' IP for the delivery of imaging	IP will be retained by the provider of services. Any new IP created by the sub-contracted party under the sub-contract will ordinarily vest with the primary provider	Normally, the IP will be owned by the new entity and be exploited by it on behalf of its owner organisations. The collaboration agreement may allow individual organisations to retain IP under certain circumstances. The aim should be to facilitate innovation effectively	Normally, the IP will be owned by the new entity and be exploited by it on behalf of its owner organisations. The joint venture agreement may allow individual organisations to retain IP under certain circumstances. The aim should be to facilitate innovation effectively
Capital investment	A methodology for the approval and financing of capital investments	All capital investments will be the provider's responsibility	Any capital investment approved by the new entity will be 'called up' from the owner trusts per their ownership shares. The collaboration agreement should define how capital investments are shared.	Any capital investment approved by the new entity will be 'called up' from the owner trusts per their ownership shares. In an LLP the formation agreement should define how capital investments are shared

Key term	Description and issues	Outsourced option (option 3.7)	Host/alliance options (options 3.1 to 3.3)	Joint venture and partnership options (options 3.4 to 3.6)
			All capital calls will require a business case approved by the imaging management board. Capital calls above an agreed threshold will require approval by the owner trusts per the scheme of delegation Any capital investments (from which the new entity will benefit) committed by potential owner trusts within three months of the creation of the new entity will be included in the valuation of ownership shares	All capital calls will require a business case approved by the imaging management board. Capital calls above an agreed threshold will require approval by the owner trusts per the scheme of delegation Any capital investments (from which the new entity will benefit) committed by potential owner trusts within three months of the creation of the new entity will be included in the valuation of ownership shares
Clinical governance	Ensuring input from clinicians and oversight of imaging service operations	Clinicians from the outsourced supplier are responsible for clinical quality and accreditation. Service to be delivered in accordance with the contract	Input into governance through the establishment of a joint clinical governance group where all shareholders have representatives. This group is independent from the operational management board and can make recommendations on clinical service performance. In addition, consultant programmed activities are bought from owner trusts to ensure consultant input into imaging service operations	Input into governance through the establishment of a joint clinical governance group where all shareholders have representatives. This group is independent from the operational management board and can make recommendations on clinical service performance. In addition, consultant programmed activities are bought from owner trusts to ensure consultant input into imaging service operations

Key term	Description and issues	Outsourced option (option 3.7)	Host/alliance options (options 3.1 to 3.3)	Joint venture and partnership options (options 3.4 to 3.6)
Imaging management board	A methodology for the day-to-day management of the imaging service	Management of the imaging service will be the responsibility of the imaging provider	The day-to-day operations of the new entity should be governed by an imaging network management board. This board should comprise non-executive and executive positions. Owner trusts can nominate representatives to take up non-executive positions An independent chair ideally will be appointed by the owner trusts The executive team will be selected, through an agreed interview process, from the appropriately qualified staff from the owner trusts If matters require the imaging management board to vote, decisions should be made using a simple majority	The day-to-day operations of the new entity should be governed by an imaging network management board. This board should comprise non-executive and executive positions. Owner trusts can nominate representatives to take up non-executive positions An independent chair ideally will be appointed by the owner trusts The executive team will be selected, through an agreed interview process, from the appropriately qualified staff from the owner trusts If matters require the imaging management board to vote, decisions should be made using a simple majority

These key commercial terms are relevant to the options under Sections 3.3 to 3.6 which involve the formation of a new legal entity:

Key term	Description and issues	New legal entity joint venture options
Trust contracts	A methodology for each trust to contract with the imaging network (the new legal entity)	Each controlling trust should agree an exclusive contract with the new entity for a defined period A seven-year initial contract period is considered the minimum required to allow for the required integration, new operating practices and economies of skill and scale to be realised, and the benefits shared between the customers and owners
Performance management	The contracts with the NHS owner trusts will include key performance metrics. If these are not met, revenue will be deducted from the new entity	As above
Imaging pricing	A methodology for pricing imaging examinations to NHS owner trusts	The new entity executive team should prepare a three-year operating plan that sets a price list for its customer owner trusts All prices will be consistently applied to the owner trusts and should decrease in real terms over time to reflect the expected operating efficiencies to be achieved by the new entity
Marketing	A methodology for the marketing of the imaging service to partners outside the current service provision	Marketing of the imaging services to trusts and organisations outside the current owner organisations should be the responsibility of each individual organisation. Each organisation will have the option, but not the obligation, to seek delivery of future additional imaging service from the joint venture under terms to be agreed at that point The customer for services marketed will need to ensure that the relevant procurement regulations are followed.
Accounting principles	A methodology for accounting for the imaging network (new legal entity)	The new entity will have its own trading account that will determine the bottom line contribution. The trading account should include all recharges for staff and services received from trusts

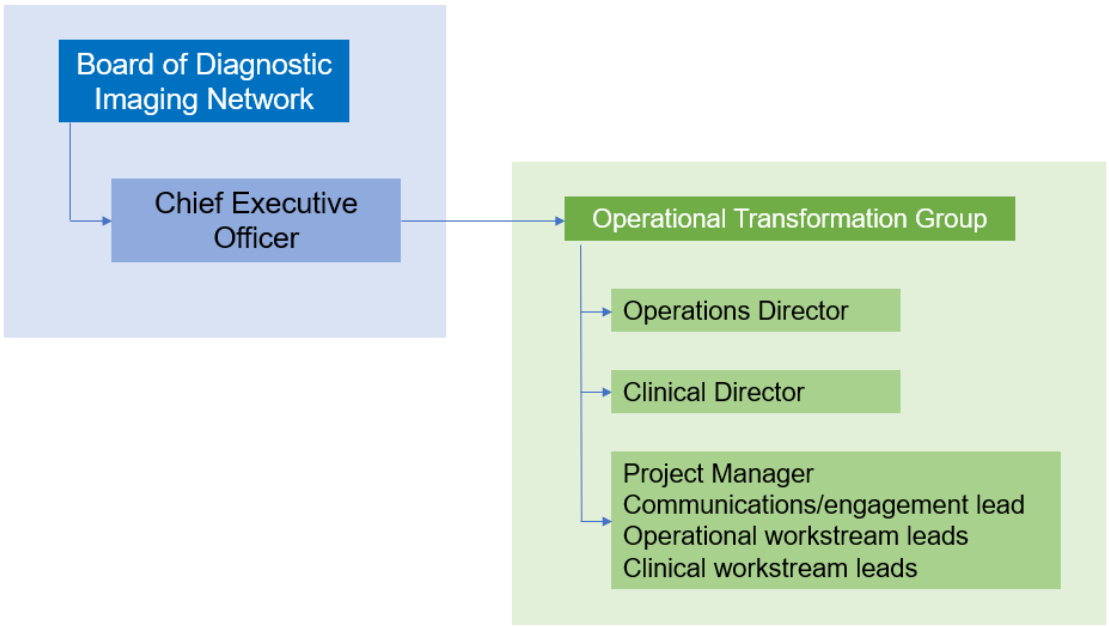
Key term	Description and issues	New legal entity joint venture options
		The trading account should be presented quarterly to the imaging management board, then to each respective owner organisation board
Corporate support	A methodology for provision of corporate support to the imaging network (new legal entity)	Corporate support services should be provided by the joint venture/and recharged based on actual costs as agreed with the new entity
TUPE transfers	A methodology for the potential transfer of staff to the new provider of the service	All imaging staff from the owner trusts may be eligible for jobs in the new entity or partnership (per its agreed operating model) Once the process is complete the appointed staff will transfer under TUPE from their current trust to the host trust (This option could be used for all staff or just for defined key posts to ensure the sustainability of the new entity) This will apply to clinical staff with the exception of those who have clinical (patient-facing) sessions. If their clinical (patient-facing) time exceeds diagnostic imaging time, the latter service will be recharged (and vice versa)
Redundancy costs	A methodology for the coverage of potential redundancy costs	Any redundancy costs should be met by the joint venture, and shares between owner organisations based on their ownership share of the joint venture Redundancy only considered after all redeployment routes are exhausted

5.4. Operational transformation group

An operational working group should report directly to the imaging board. This group is responsible for delivering the objectives set out by the imaging board and is chaired by the chief executive. Representation should include the operations director and leads from all clinical and operational workstreams.

The remit of the operational working group is to drive the objectives of the board, and report progress and barriers as well as risks and opportunities.

Project management should be run from the operational working group with key decisions presented to the board for approval.



5.5. Workstreams

The imaging network operation should have a dedicated workstream group for each clinical discipline and key operational function.

Suggested groups include (but are not limited to):

- paediatrics
- neurosciences
- cardiovascular
- thoracic
- musculoskeletal
- head and neck
- breast
- gastrointestinal and abdominal
- urogenital
- dental and maxillofacial.

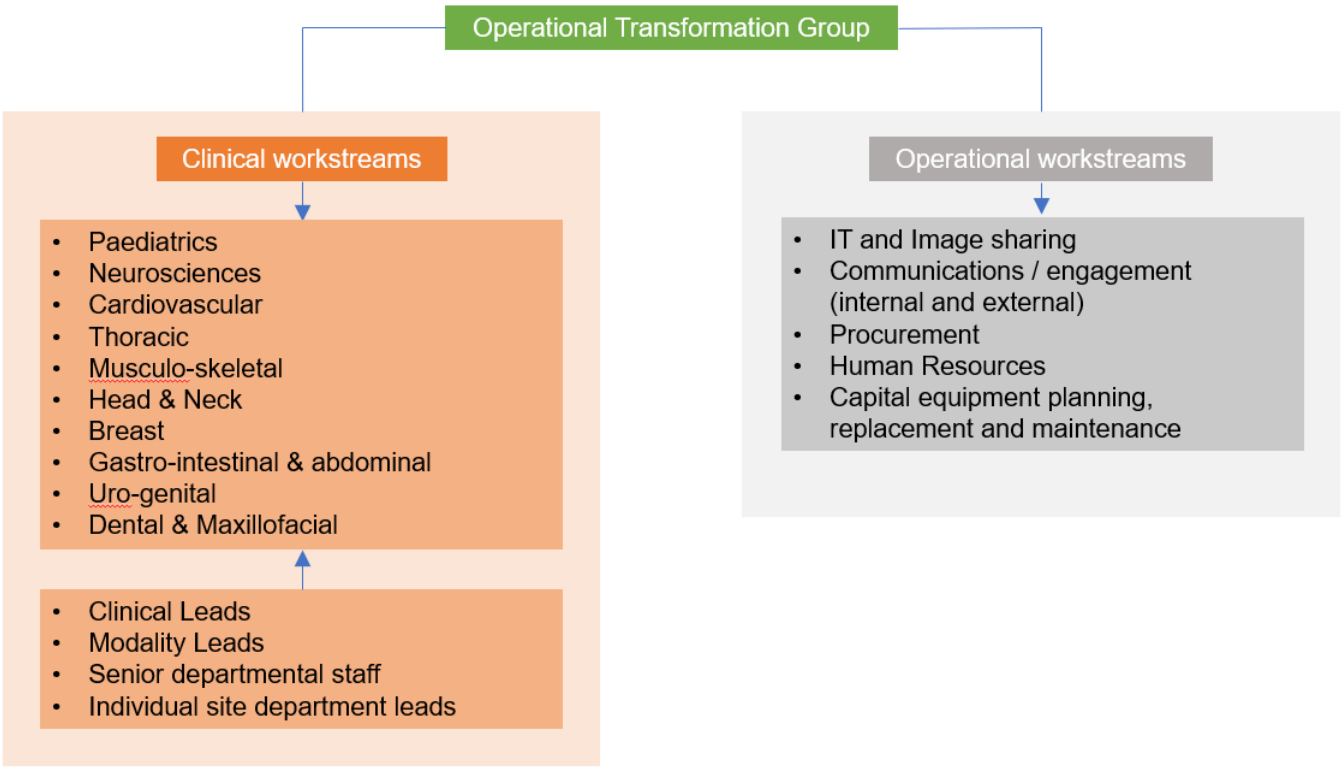
Networks may also choose to establish workstream groups of each imaging modality, eg CT, MRI, ultrasound, nuclear medicine, interventional radiology, etc.

Each of these groups should have imaging services management representation and discipline lead representation from each of the individual trust sites. Clinical lead engagement will be crucial during the design of the future state model for each clinical discipline.

Operational workstream groups should be formed for:

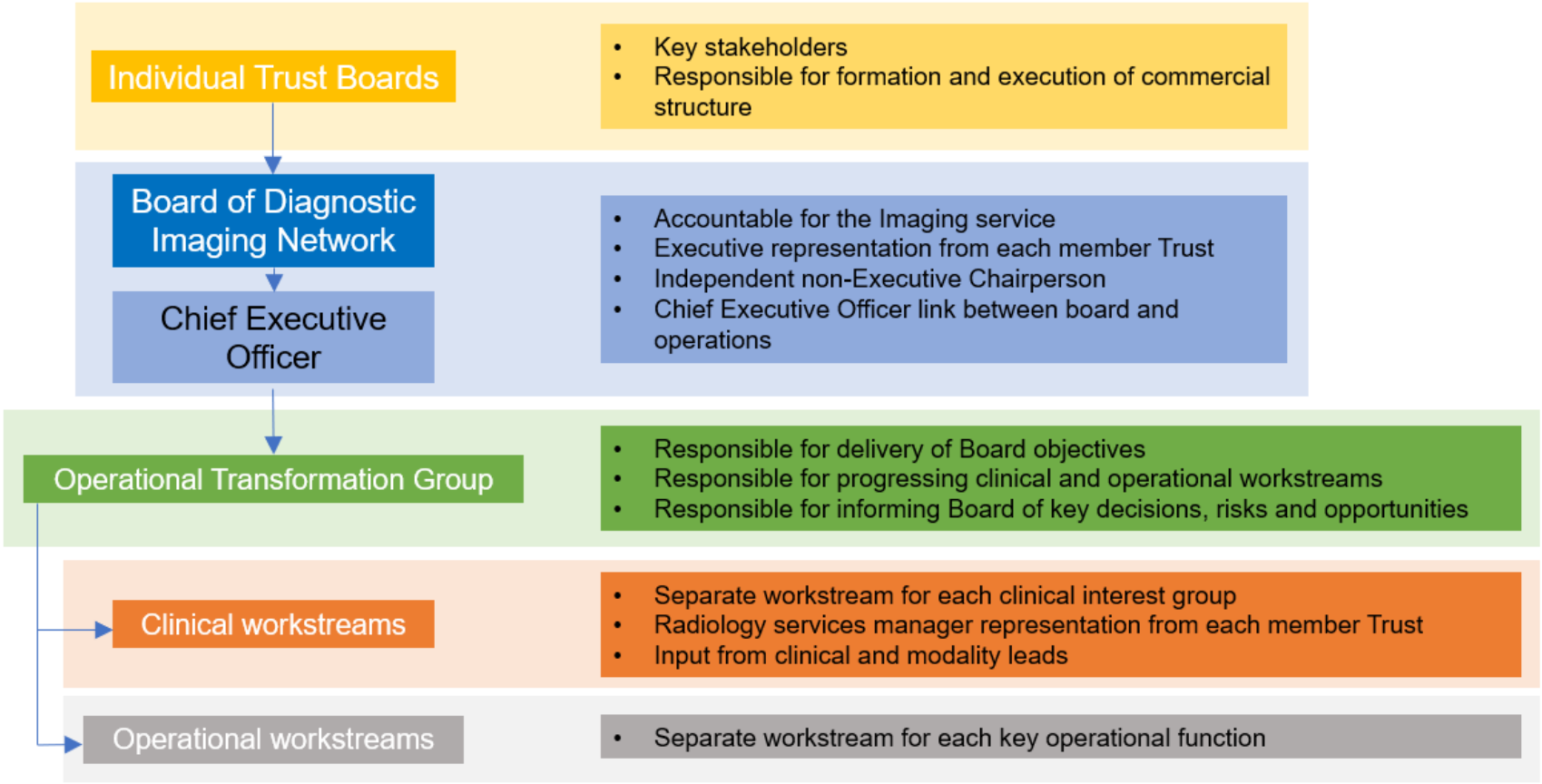
- IT and Image sharing
- communications/engagement (internal and external)
- procurement
- human resources
- capital equipment planning, replacement and maintenance.

These groups should meet at the frequency required to progress their individual workstreams toward the target operating model. The workstream lead reports into the operational working group.

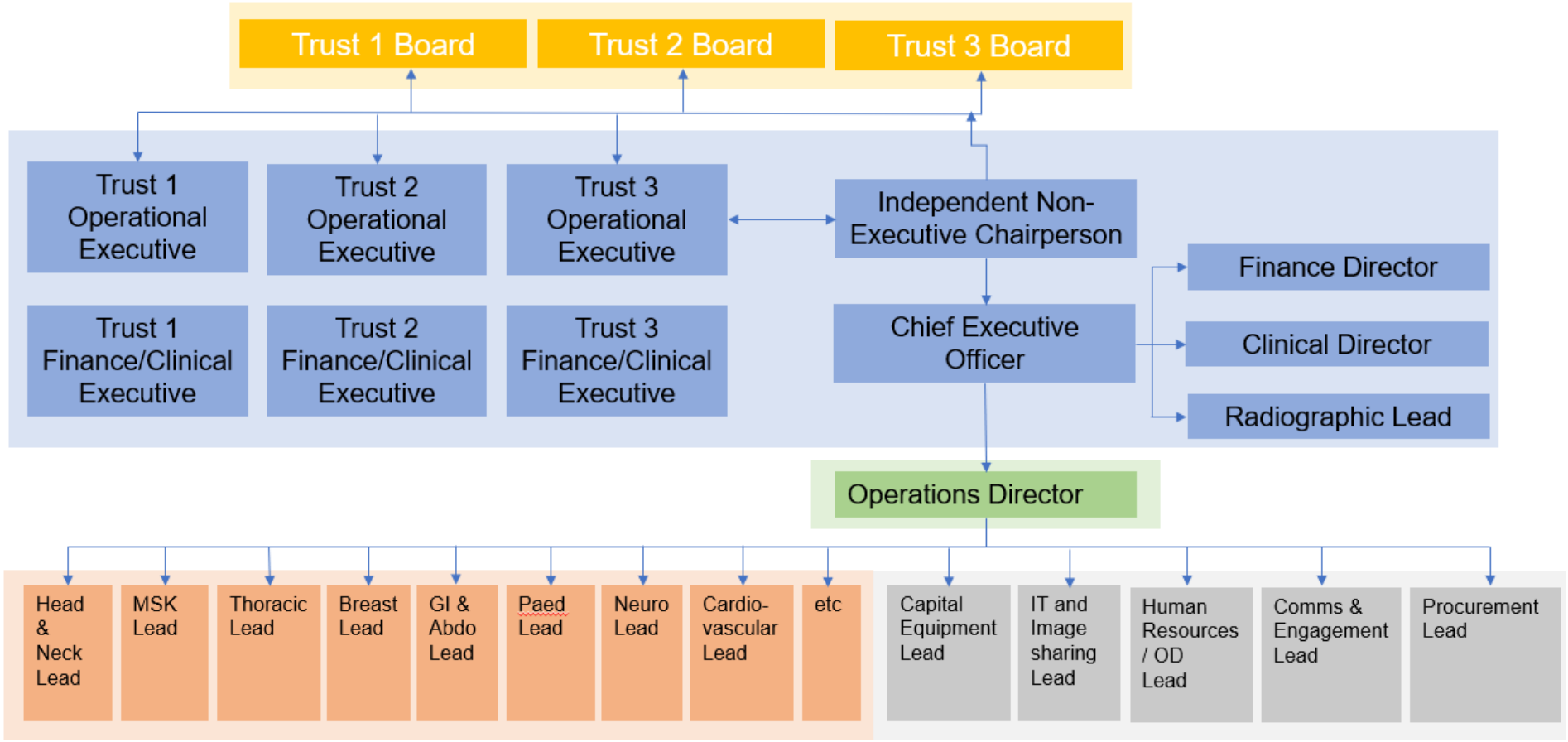


5.6 Summary of operational governance principles and structure

Principles



Structure


Trust 1 Board
Trust 2 Board
Trust 3 Board
Trust 1 Operational Executive
Trust 2 Operational Executive
Trust 3 Operational Executive
Independent Non-Executive Chairperson
Trust 1 Finance/Clinical Executive
Trust 2 Finance/Clinical Executive
Trust 3 Finance/Clinical Executive
Chief Executive Officer
Finance Director
Clinical Director
Radiographic Lead
Operations Director
Head & Neck Lead
MSK Lead
Thoracic Lead
Breast Lead
GI & Abdo Lead
Paed Lead
Neuro Lead
Cardio-vascular Lead
etc
Capital Equipment Lead
IT and Image sharing Lead
Human Resources / OD Lead
Comms & Engagement Lead
Procurement Lead

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