hfma briefing

Contributing to the debate on NHS finance
May 2013

Partnership working in the NHS

An overview of why and how partnerships are formed in the NHS

Foreword

The Healthcare Financial Management Association (HFMA) is the representative body for NHS finance professionals. With a 60-year history, it has a long track record in issuing authoritative guidance, delivering training, and helping to spread best practice in financial management and governance.

The need to look for new opportunities for joint working (in all its forms) to improve the quality and efficiency of healthcare provision is increasingly important – especially as the structure for the NHS set out in the Health and Social Care Act 2012 is implemented, at a time of financial constraint throughout the public sector.

In addition, new commissioning organisations will increasingly be looking to commission care pathways to deliver improved outcomes for patients. This will need healthcare provider organisations from all sectors to work closely together in new ways and with new partners.

This is an exciting and evolving agenda and while this briefing is not meant to be prescriptive, it is offered as an introduction to a business area in its infancy in the NHS. It provides an overview of why and how partnerships are formed in the NHS with public, private and third sector organisations. It will also look at practical considerations to be taken into account when thinking of developing a partnership. Whatever the preferred arrangement, all those involved need to look to achieve a real advantage to patient care and value for money through a new way of working. This also offers a real opportunity for finance professionals to develop personally and professionally.

The HFMA is active at national and local level in raising the awareness of how NHS finance works, influencing policy development and raising the skill base of those involved in financial management. We support NHS organisations and individuals in improving financial management and governance through periods of challenge and change, which is particularly important as the new structure of the NHS becomes established.

We trust that you will find this briefing helpful and would be delighted to hear your feedback (publications@hfma.org.uk). We would also welcome any suggestions you may have for ways in which we might support you and the development of your organisation.

Simon Wombwell, chair of the HFMA Foundation Trust Technical Issues Group

It is important to identify what the partnership is aiming to achieve, who to partner with and what form the partnership should take

Introduction

The need to provide services in a more cost-effective, seamless way is driving all NHS bodies to explore new ways of working. NHS providers are increasingly looking to joint working in all its forms to improve quality and patient experience, the efficiency of healthcare provision and to deliver savings by integrating services, collaborating with public, private or third sector organisations.

Partnership is a form of integration with a spectrum ranging from cooperation on occasional projects to the forming of a legal company. Although not every option is open to every type of NHS organisation, a partnership of some type will be possible if a suitable opportunity arises.

When looking to establish a partnership, it is important to identify what the partnership is aiming to achieve, who to partner with and what form the partnership should take in order to ensure the arrangement is an effective, efficient way to achieve the shared goal.

Although not exhaustive in its coverage, the briefing will provide an overview of why and how partnerships are formed in the NHS and look at some practical considerations to be taken into account when they are developed.

What are partnerships?

While the types of partnership that can be established by an NHS (non-foundation) trust are limited, foundation trusts have a greater degree of flexibility and additional statutory powers to enable them to develop NHS services through partnerships.

This may be through the creation of separate entities or more straightforward contractual arrangements and corporate structures.

As the NHS moves towards an all-foundation trust provider sector, these options will be available to an increasing number of NHS organisations.

Although there are many different arrangements that fall under the banner of 'working in partnership' they can be summarised as follows:

- Shared services – for example, consortium arrangements to deliver pathology services
- Integrated working (between two NHS bodies or between the NHS and a local authority):
  - The provision of substance and alcohol misuse services
  - Working with local authorities under section 75 arrangements
  - Vertical integration for the provision of a whole patient pathway.
- Contractual outsourcing:
  - A contractual agreement with a limited liability partnership to provide clinical services for NHS patients
  - Outsourcing of back-office functions such as finance and HR
  - Commercial arrangements under which an NHS organisation provides a service such as the provision of sterile services or pharmaceutical activities
  - Subcontracting part of a process or service.
- Concessions:
  - A private sector company operating a café within a hospital.
- Joint ventures:
  - Public private partnerships – private finance initiatives (PFI) and local improvement finance trust (LIFT) schemes in the past; Private Finance 2 (PF2) arrangements in the future (under PF2 , the government will act as a minority equity co-investor with investments managed by a central unit located within HM Treasury)
  - To develop new capital infrastructure.

The briefing will look at each type of partnership structure in turn and provide a number of case study examples to illustrate how the arrangements can work in practice.

This is also an area of change and development. The Department of Health recently announced the creation of a new organisation, Healthcare UK, to facilitate the development of partnerships between UK healthcare and overseas organisations.

According to its January announcement, the Department revealed that 'Healthcare UK aims to boost the value of the UK's trade in healthcare products and services' by providing a 'gateway' to UK health expertise for overseas organisations, including those in the Middle East and China.

Why work in partnership?

In the context of the wider strategy of all organisations, working in partnership can help an organisation achieve something it wouldn't otherwise be able to. Therefore, it is important to establish the shared aim to be met through the arrangement (see case study right).

As the case study demonstrates, a key part of the initial exercise is the identification of the financial and non-financial aims of the project with the goal of improving service delivery for patients and delivering value for money for the public sector. Considerations here may include:

- Securing capital investment
- The generation of income to be reinvested in frontline patient services – for example, using surplus capacity to generate a rental income or entering into a partnership overseas
- Increasing market share/presence
- The development of research and/or academic opportunities
- Developing improved and/or expanded models for service provision (see case study overleaf)
- Achieving economies of scale and/or delivering efficiencies
- Achieving sustainability by bringing in new resources.

The need to clearly identify the aim is highlighted in Monitor's document *Applying for NHS foundation trust status: guide for applicants,* in which an applicant trust is asked to consider what it 'is hoping to achieve and how it shall perform its duties within the partnership'.

For any organisation, it is vital to be clear about the aim of the partnership and to look for the best way of achieving that aim. This needs careful identification of the issue(s) requiring resolution, as well as thorough and accurate plans that are reflected in the organisation's business plan.

If the solution is partnership, one option will not fit every organisation on every occasion. It is also worth remembering that the individual organisations forming the partnership retain accountability and statutory responsibilities, even when the aim is best achieved by working together.

CASE STUDY: LONDON PROCUREMENT PARTNERSHIP

The NHS is often criticised for failing to use its buying power when procuring goods and services, but the Royal Free London NHS Foundation Trust and the Whittington Hospital NHS Trust have implemented a partnership solution that increases the value for money provided by their procurement service.

A shared service arrangement went live in December 2010 and has produced significant savings by allowing the trusts to buy at scale, reducing transaction costs. Procurement Shared Service (PSS) director Alan Farnsworth says it is also standardising and rationalising the products used in the trusts, in association with their clinicians. PSS buys all goods and services for the trusts, except pharmaceuticals.

'We have our own cost improvement programme and have reduced the total revenue cost of running the service over the past two years by 22% and have delivered on average £4m of cash-releasing recurrent benefits a year,' he says.

PSS has implemented a new e-procurement system at the Whittington and is gearing up to help introduce a new finance and planning system at the Royal Free in summer 2013. The move to a shared service was prompted by the belief at both trusts that their procurement departments could be more effective. With the backing of the chief executives, Mr Farnsworth scoped out the potential for a procurement shared service. A key principle at the beginning was that the partnership would be equal, even though at the time the Royal Free was a much bigger trust.

Though PSS operates on both trust sites, most procurement staff are based at the Whittington. However, Mr Farnsworth says it is clear they are working for both trusts. 'Our people are cross-trained. Even though the trusts operate two finance and procurement systems, they can use both. If the workload spikes in one trust, we can move the resources across to deal with it.'

The shared services organisation's buying power will expand significantly in summer 2013, when it is due to become UCL Partners Procurement Service and a further four academic health science partnership trusts are expected to join.

The service has its own graduate recruitment scheme that addresses the dearth of skills in the general job market. Graduates receive on-the-job training, allowing the partners to develop their own procurement specialists.

CASE STUDY: SOUTH STAFFORDSHIRE THERAPIES TIE

Working with a charitable organisation has enabled South Staffordshire and Shropshire Healthcare NHS Foundation Trust to provide improved access to psychological therapies (IAPT) for local patients and through a number of IAPT services across the UK.

The trust subcontracts the low-intensity patient interfaces to Mental Health Matters, a charity that provides support for people with mental health needs across the UK. The trust provides the high-intensity aspects of the service that need the input of qualified staff. The charity also rents the accommodation on behalf of the whole service, enabling patients to be seen outside a hospital setting, thus supporting local access and non-stigmatising facilities.

The arrangement has enabled patients to receive a high-quality, integrated service which is cost-effective for the trust to provide.

Types of partnership structure

Collaborative arrangements

Shared services

Services may be shared with another NHS body or bodies and may include hosting a service, using a shared structure or establishing a subsidiary to deliver change and cash-releasing savings.

Under this model, the service remains in the NHS, although a structure is introduced to deliver the service. The arrangement may be underpinned by a cooperation agreement and is likely to make use of service level agreements to specify to partners what services will be delivered, when and for what value. For example, Liverpool Clinical Laboratories is a collaborative pathology service largely hosted by Royal Liverpool and Broadgreen University Hospitals NHS Trust; service level agreements are in place with partner organisations (foundation and non-foundation).

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Integration

Integration is a well-established model of public service delivery, whereby partner organisations work together to deliver integrated service provision tailored to local circumstances. It may be horizontal, where two providers of the same service integrate, or vertical to provide all stages of a patient pathway or service. Integration may be within the public sector or between the NHS and the private or voluntary sectors.

For example, the stroke pathway in north Essex is commissioned from both an acute and private sector provider. This has been achieved by unbundling the service and tariff payment and transferring resources previously invested in the acute provider to the community provider (a local social enterprise that manages the service) within the existing resource envelope.

NHS services can also be integrated with other non-NHS public sector organisations. So, a local authority under section 75 arrangements. Although this type of integration is well established, the Health and Social Care Act 2012 has strengthened the role of local authorities, increasing their ties in local health economies. They now have a statutory responsibility to join up commissioning of NHS services, social care, public health and health improvement. In practice, this means many of the existing joint working arrangements will continue alongside additional statutory responsibilities in relation to health.

Health organisations and local authorities can form partnerships in a number of ways:

- Local strategic partnerships – non-statutory, non-executive, multi-agency bodies
- Care trusts – statutory NHS bodies to which local authorities can delegate (not transfer) health-related functions with the aim of providing integrated health and social care to the local community
- Section 75 flexibilities, under the National Health Service Act 2006:
  - Pooled budgets – partner organisations contribute agreed funds to a single pot, enabling a local authority and an NHS body to combine resources and jointly commission or manage an integrated service.
  - Aligned budgets – partners share information, priorities and strategies, and agree a way forward but the management of budgets, as well as monitoring and reporting, are kept separate. An aligned budget can be used as an interim stage to running a pooled budget.
  - Lead commissioning – partners agree to delegate commissioning of a service to a lead organisation.
  - Integrated provision – partners join together staff, resources, and management structures so the service is fully combined from managerial level to the front line. One partner acts as the host for the service to be provided.

The 2012 Act allows all these flexibilities to continue but places a duty on clinical commissioning groups (CCGs) and local authorities (through the Health and Wellbeing Board) to consider how to make best use of the flexibilities when drawing up the Joint Strategic

Needs Assessment (JSNA) and Joint Health and Wellbeing Strategy (JHWS). A JSNA is drawn up by local authorities and CCGs to identify the current and future health and well-being needs of the local population, while JHWSs set out the issues requiring greatest attention by key commissioners and how they will work together to deliver the agreed priorities. To reinforce this duty, NHS England has a duty to promote the use of flexibilities by CCGs.

Commercial arrangements

Outsourcing and subcontracting

This involves transferring all or part of a service to a partner organisation. Used for many types of arrangement, it is important to consider length of contract with the provider and the associated cost. Where a subsidiary company is established for trading activities, this is effectively transferring the entire service provision to another provider.

Although traditionally used in relation to the non-core business of NHS organisations – for example, back-office functions such as finance and payroll – it is increasingly being applied to middle-office and frontline clinical services, as demonstrated by the example in the box below.

Concessions

Although unlikely to be suitable for clinical activity, concessions offer the market the opportunity to run a service – for example, a shop or café. It normally involves a lease and may take the form of a franchise. As the service operates out of the NHS organisation's property, safeguards must be incorporated into the contract when the lease arrangements are agreed. This arrangement can generate income for the host with a percentage of the profits earned returned to the NHS organisation.

Joint ventures

Although there is no legal definition for a joint venture, it is usually established over the long term and involves the sharing of both risk and reward – the collaboration between two or more organisations to achieve a joint aim. This can be via a contractual agreement (contractual joint venture) or through the creation of a new entity (corporate joint venture).

Issues to consider if setting up a joint venture are:

- The scope and duration of the venture
- The services being provided
- What the parties are committed to do
- What the termination triggers are and how the assets and liabilities are then dealt with
- Staffing arrangements
- Arrangements for financing the venture
- Partners' profit entitlement (or liabilities).

Contractual joint venture

Here, the organisations involved remain separate legal entities with their own identity and retain their own liability. However, they do have access to each other's resources and brands, although the arrangement is normally time-limited.

Corporate joint venture

Here, the organisations involved choose to establish a separate legal entity with a separate identity and brand. This may take the form of one of the following:

- A company limited by shares/guarantee that can be public or private
- A limited liability partnership
- A social enterprise or charitable organisation – a community interest company or charitable trading company.

On establishing the joint venture, three possible scenarios exist:

- The parties to the arrangement transfer staff and assets to the joint venture company, which goes on to provide services to a third party
- The joint venture company is the contracting body and has individual subcontracts with the NHS organisation and/or private sector partner for their respective contributions to the services
- Equity is transferred to the joint venture company from both the NHS organisation and the private sector partner. The joint venture

In contractual joint ventures, the organisations remain separate legal entities with their own identity and retain their own liability. However, they do have access to each other's resources and brands

CASE STUDY: SOUTH STAFFORDSHIRE DEFENCE LINK

South Staffordshire and Shropshire Healthcare NHS Foundation Trust acts as lead contractor of an NHS network to provide mental health inpatient services on behalf of the Ministry of Defence and United States Air Force Lakenheath. The network covers all UK and international requests. To comply with contract requirements, service personnel must have access to a mental health hospital bed within four hours of request and travel to the appropriate mental health services within two hours from the MoD base. The trust has partnered with several other mental health foundation trusts and Scottish NHS trusts to deliver the required services across the country. All the NHS organisations involved work to a single MoD/NHS service specification to ensure consistency of provision, and are managed through a single point of access.

The trust leads all contract discussions with the MoD, deals with all issues relating to service provision irrespective of where it is provided, and handles all income and payments on behalf of the other organisations.

company then provides services back to the NHS organisation under a contract.

Limited liability partnerships

Here, resources are pooled via a contractual arrangement where the parties involved are jointly and severally liable for any combined or individual losses that may be incurred. The parties also agree to share profits in agreed proportions. NHS organisations may use limited liability partnerships to provide clinical services for NHS patients. For example, York Teaching Hospital NHS Foundation Trust buys some orthopaedics services from a local limited liability partnership.

The table below outlines the advantages and disadvantages of different partnerships. It is worth noting that a partnership arrangement can arise unexpectedly as an 'unintended consequence' when working with another organisation.

THE KEY ADVANTAGES AND DISADVANTAGES OF EACH TYPE OF PARTNERSHIP

Arrangement	Advantages	Disadvantages
Shared services	Control retained by partners Services kept in public sector Attractive to staff Can be set up without going through a procurement process	Limited savings No additional capital available Unclear accountability May be difficult to bid for new work as outside original scope of purpose for which it was set up
Integration with local authorities	Service provision better for patients and improves outcomes Familiar model Services kept in public sector Attractive to staff Risk sharing possible	Limitations on use Limited savings No additional capital Governance more difficult
Subcontracting	Simple to set up Access to subcontractor's resources/ capital/ brand etc Control retained by partners Cost-effective Able to transfer risk	Total reliance on lead contractor to fulfil obligations Access to subcontractor's resources may be limited Costs associated with risk transfer
Outsourcing	Transfer risk to provider Private sector expertise Decisions taken outside the NHS body give a different view Outcome-based specifications can deliver better services Access to new sources of funding Introduce new technology	Fixed costs of the contract may be less flexible than providing a service in house Failure of contractor could be critical Passing ability to make savings to private sector Paying for contractor to take risk Potential for a loss of local jobs Requires strong contract management
Concessions	Transfer risk to provider Harness private sector expertise Exploiting opportunities Avoids distraction from core business Share in success Access to new sources of funding Introduce new technology	Not suitable for mainstream activity
Contractual joint venture	Simple to set up No permanent structure – easy to dismantle Retention of own assets/direct interest in assets Higher degree of control Access to partner's capital/ resource/ brand etc May be TUPE advantages Each party retains own liability	No limited liability Greater ongoing involvement Difficult to develop brand Potential for no disposable assets Complex arrangement Harder to introduce new third parties Potential for lack of investment No profit sharing
Corporate joint venture	Separate identity and brand Limited liability of members Flexible capital structures Easier for third parties to join in Easier business disposal Funding borrowed by joint venture Profit sharing possible Attractive to private sector partner Clearer governance framework	Complex and expensive to establish Risk of liability (subject to guarantees) Public information Subject to Companies House required reporting Tax liabilities incurred Requires separate management Agreement needed as to how profits are passed on to partners including payment of any dividend

SOURCE: WORKING IN PARTNERSHIP, BEVAN BRITTAN, SEPTEMBER 2012

Choosing the right model and making it work

Key factors

According to the Foundation Trust Network, the type of partnership model chosen is driven by:

- The extent to which risk needs to be contained
- The impact on existing NHS services, patients and staff
- Requirement for funding
- The need to access third-party skills
- The use to which profits are to be put
- The need to accommodate any exit strategy.

Initial considerations are best followed by a full options appraisal, including an analysis of strengths, weaknesses, opportunities and threats (SWOT analysis) – a key part of the planning process, particularly when considering major business decisions. It can also help to determine whether or not a partner is likely to prove to be a good fit.

Potential pitfalls

However thorough the planning of a project and whatever form the partnership arrangement may eventually take, it is wise to be aware of the potential pitfalls at an early stage:

- The perceptions of stakeholders, particularly patients and service users – early misperceptions can be difficult to rectify
- Collaborating to design the service rather than imposing a solution – design should involve key stakeholders at all levels in the organisations concerned
- Insufficient ambition – allowing thinking to be limited by the existing culture of the organisation
- Inadequate preparation and resources needed to establish the partnership itself
- The absence of a common understanding of the partnership's aims and responsibilities – can result in or be the result of a lack of commitment at all levels
- A lack of clear accountability to the partnering organisations and the subsequent difficulty of tracking decisions back to the accountable organisation
- A lack of clear reporting structures from frontline staff to the relevant governing body
- The potential to lose control over financial and other resources – can be stretched when others are authorised to make decisions on behalf of the organisation
- The absence of clear boundaries around what is and is not covered by the arrangement – can be hampered by a failure to put a signed agreement in place
- Intangible cultural and/or ideological differences and rivalry – may create tensions between the partnering organisations
- A disjointed process/pathway in patient-facing services – a patient should not be aware that they are moving between providers; there should be no gaps in provision
- A failure to identify and therefore mitigate the risk to both corporate and individual reputations
- A failure to understand the statutory requirements
- A failure to establish outcome measures and report against them
- The absence of an agreed exit plan so that partners know what will happen when the partnership ends.

In endeavouring to avoid these pitfalls, it may be helpful to take the following considerations into account when undertaking the initial analysis, as well as during the life of the project.

Practical considerations

Stakeholder support

Ensure support for the project within the local health economy and embark on a formal consultation process if appropriate. It is also important to engage with and shape the perceptions of patients, service users, the public and members, as well as staff and governors/members. Communication will be needed at the start of the project and throughout its lifetime.

Commercial considerations

A commercial (rather than NHS) approach to the project may be more appropriate, particularly in terms of decision-making, costs, assumptions and risks. It is also important to consider the potential for a profit to be made, any change in market share and the role of new or potential competitors in the wider scheme.

Legal considerations

Although outside the scope of this briefing, it is important to consider some or all of the following issues:

- Competition law
- Dispute resolution procedures
- The existence of formal agreement templates – for example, those underpinning section 75 agreements

A commercial (rather than NHS) approach to the project may be more appropriate, particularly in terms of decision-making, costs, assumptions and risks

- Compliance with Companies Act 2006 requirements.

Appropriate professional advice should be sought as needed.

Hosting arrangements

Working out who will host the partnership is an important decision that involves practical questions – for example, which organisation currently employs the majority of staff.
This will need to be followed by discussions concerning:

- The provision of administrative support
- The provision of estate, including where the service is to be accommodated
- The provision of IT, including the financial systems
- The provision of a procurement service to the partnership.

Financial considerations

Financing capital expenditure and asset ownership

The potential sources of funding for capital investment vary by type of NHS and partner organisation; not every source of funding will be available to every type of organisation.

For example, a foundation trust can borrow from a commercial bank, while an NHS trust can only borrow from the Department of Health. In addition, borrowing must be affordable for all NHS organisations.

When looking at how to finance the proposal, the impact of a partnership arrangement on existing borrowing must be considered. The way in which capital investment is undertaken must be thoroughly considered and modelled. Monitor's *Risk evaluation for investment decisions* is particularly relevant here.

Financial risk ratings

The risk of financial failure of the organisation is also a concern. Foundation trusts must continue to comply with Monitor's Compliance Framework now and Risk Assessment Framework in the future. Any impact on the relevant metrics must be considered by the board.

For example, does any loss made by the partnership come back into the host and if so, what is the impact on the metrics? Similarly, how much loss can the host organisation sustain before financial failure is a serious concern and is the board aware of the tipping points?

Budgets and ongoing financial control

Throughout the life of the partnership, all parties must be involved in setting the budget and its subsequent control. It is worth considering the inclusion of a contingency within the initial budget and during the early period of operation. This will help to manage the financial risk without recourse to the partnering organisations. Financial plans should also include the delivery of realistic savings where appropriate.

To make good financial control possible, the treatment of revenue costs, including taxation, should be understood and agreed by all the organisations involved. There may be a difference in the VAT and corporation tax regimes of partner organisations (the latter in the case of limited companies) and professional advice may be required.

Financial reporting

In order to discharge all statutory responsibilities to the taxpayer, proper and consistent accounting and reporting is needed throughout the year and at year-end. This will require financial reporting to be transparent and aligned throughout the year as well as a clear understanding of how the reporting of the partnership's financial performance fits into that of the wider organisation. This can be facilitated by all those involved having concurrent financial years with the same year-end date.

The accounting treatment of transactions, profits and losses and recognition of areas where the potential for a year-end dispute exists can be dealt with explicitly in the partnership agreement. It may be helpful to outline the proposed accounting treatment in the agreement itself with the action to be taken if a dispute were to occur.

This can help to avoid a situation whereby two organisations have outstanding balances accompanied by an explanation acceptable to their own auditors but a different technical treatment means neither can change their reported position.

It can be helpful to implement the same billing and payment arrangements as for healthcare services covered by the NHS standard contract, ensuring that neither party has a cash flow benefit. It can also be helpful to include sufficient narrative on invoices to indicate how the transaction will be accounted for at year-end to avoid later confusion.

To discharge all statutory responsibilities to the taxpayer, proper and consistent accounting and reporting is needed through the year and at year-end

Governance arrangements

The partnership agreement should incorporate all governance and risk-sharing arrangements in relation to the service being provided and the accompanying contract.

It is important to consider and have measures in place to avoid the blurring of the relationship between the hosting trust and the partnership. Confusion must be avoided in relation to responsibility and accountability, particularly where the partnership board is populated by the organisation's own staff, including directors.

In this instance a conflict of interest can arise as the individual is representing both the customer (the NHS organisation) and the supplier (the partnership organisation). It is important to have sufficiently robust arrangements in place to ensure that the partnership is acting independently and conflicts of interest are identified and appropriately managed.

This can be facilitated by clearly setting out roles and responsibilities in the partnership agreement for example, who manages expenditure and/or savings. It is also important to think through a strategy for dealing with a situation where the partner organisation is subject to intervention by the regulator or is unable to deliver its service.

The NHS organisation must ensure that all its obligations are met, even if the partner organisation is unable to deliver its part of the service.

It can help to consider the assurances and evidence required in relation to self-certification by the board. To that end, the board and audit committee must be suitably assured that proper and proportionate arrangements are in place to manage the business risk associated with the partnership arrangement.

Impact on human resources

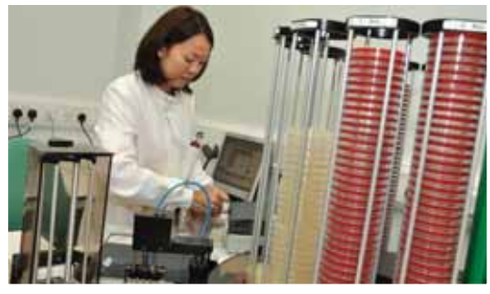
The impact of the partnership arrangements on staff in all organisations must be considered. Here, it is important to consider:

- Is a Transfer of Undertakings (Protection of Employment) or TUPE transfer involved (this preserves employees' terms and conditions when a business or undertaking, or part of one, is transferred to a new employer)?
- Are any secondments to the partnership required?
- Can the duties associated with specific posts be integrated to greater effect?
- Will a change to employees' contracts be required?
- Will a consultation period be needed?
- Are the terms and conditions of staff from each partner compatible?
- Who will provide operational management and supervision? How will this work on a practical basis?
- Which organisation's policies are to be applied – for example, in relation to performance management?

CASE STUDY: COUNTESS OF CHESTER AND WIRRAL LABS SCHEME

The Countess of Chester Hospital NHS Foundation Trust and Wirral University Teaching Hospital NHS Foundation Trust are working in partnership to provide a modern, off-site microbiology lab, which they say will deliver significant financial benefits, improve quality and workflow efficiency. The move was prompted in part by the need for both trusts to make significant savings and a national NHS pathology review, which identified potential improvements in microbiology laboratory infrastructure, turnaround times and the range of tests, as well as financial efficiencies.

MicroPath, as it is known, became operational in April 2012 and won the Efficiency Award at the HFMA 2012 Awards. The trusts say annual savings of £800,000 have been released – more than 20% of the base budget. The business case outlined a £5.4m return over 10 years and a 45-month payback period for the initial capital investment – the project is on track to deliver these milestones.



Implementation of MicroPath began in earnest in September 2010 and took 19 months to complete – the trusts say this is a result of strong leadership and robust project and operational management. The project had a capital budget of £2.2m, split equally between the trusts and used to buy and adapt a building on an industrial estate and the necessary equipment. Savings were generated by the decision to locate the service in pre-built accommodation – the cost of purchase and redevelopment of the industrial unit was 45% lower than a traditional NHS build (£2.2m compared with almost £3.98m).

The partners agreed a new staffing model, which included 18 fewer whole-time equivalent staff achieved by natural wastage and voluntary severance schemes. The lab has also been designed with flexibility for the future – it can expand to meet demand and can accommodate automation when this is required.

Richard Baird, divisional director at the Countess of Chester, who worked across the trusts during the project, says the pathology initiative could be replicated in trusts across the country. 'The two trusts had labs that weren't fit for purpose and had to do something about it. Going off-site created efficiencies and gives us greater flexibility for the future,' he says.

Commitment to the arrangement must be present throughout the organisation. There can be problems if clear leadership at all levels and in all disciplines is absent

Clear leadership

Successful partnerships are largely based on two organisations working well together, led by two like-minded senior managers who can agree on how to work together to improve clinical outcomes. This can be seen in the Countess of Chester case study on the previous page.

However, the commitment to the arrangement must be present throughout the organisation. There can be problems if clear leadership at all levels and in all disciplines is absent. Early consideration and effective planning enables the partnership to become embedded in the organisation and continue unaffected when key individuals leave.

Summary

In each area of the arrangement outlined above, it is important for partnering organisations to take joint responsibility for identifying problems and finding solutions while balancing:

- Financial contributions and ongoing investment
- The financial and non-financial risks and benefits. There should be a clear assessment and understanding of where they fall and how they are shared between the partners. This should also include the extent to which each organisation is exposed to the identified risks
- Governance arrangements such that they are proportionate to the size, purpose and budget of the partnership while allowing effective decision-making at the right level of the organisation. It is important to identify which decisions should be reserved to the statutory bodies and which decisions can be taken within the partnership arrangement itself.

TOP 10 TIPS: GOOD PRACTICE TO MINIMISE DIFFICULTIES

The following may be helpful when considering a partnership:

- Consult with stakeholders and ensure communication is clear, timely and accurate, both externally and internally – clinical buy-in is essential.
- Engage the board – success will depend on support from and agreement within the organisation alongside a commitment to collaborate to achieve a common goal.
- Establish a project plan and team early on (in relation to the size and complexity of the proposed project) and be sure where and when to seek professional advice. Be clear about what is being asked of the professional advisers.
- Know your partners well and ensure that the business structure has been agreed before the project is under way.
- Put a signed agreement in place so that all parties are clear about committed resources, funding, accountability and reporting arrangements. This needs to be reviewed regularly to ensure that the arrangement continues to meet its aims and remains appropriate during the lifetime of the partnership.
- Identify clear roles and responsibilities within the governance framework, including a shared view of key risks. It can be helpful for the NHS organisation's finance committee to regularly review financial reports. Similarly, the audit committee could oversee a joint assurance framework that identifies reputational risks, the risk of the failure of partners, and actions to mitigate those risks.
- Create systems for sharing data and information including a single data model ideally providing real-time financial and non-financial information to support decision-making.
- Develop agreed performance targets and a mechanism to give early warning of issues as they arise. This should include services that are outsourced to suppliers or provided by partners.
- Develop clear policies and procedures on handling complaints, whistleblowing, health and safety, and counterfraud. All policies should be in place from the very beginning of the arrangement.
- Plan the partnership over time, recognising that it will need to become established in order to deliver results. There should also be clear and agreed guidelines in place for all parties to review the arrangement.

Conclusion

Variations in partnership arrangements stem from the organisations involved and how and what is trying to be achieved. These variations can also influence who to partner with to deliver the agreed aim.

Whatever the preferred arrangement, all those involved need to look to achieve a real advantage to patient care and value for money through a new way of working – by achieving more together than would have been achieved alone.

As the Audit Commission's *Means to an end: joint financing across health and social care* points out, "The focus should be on outcomes and efficiency gains achieved rather than the process of partnership working or the method by which the service is financed."

The board needs to be clear about:

- What the partnership is for
- Its duration
- Governance, financial and monitoring arrangements, including outcome measures and how to tell whether the partnership is working and achieving what was intended
- What happens in the event of termination
- When to seek appropriate professional advice.

While being risk-aware – rather than risk averse – it is also important to remember that a partnership is not the solution to every problem. However, if it is the chosen route, making the benefits of the arrangement transparent will ensure that the partnership is seen as being in everyone's best interests.

And, as the King's Fund argues in its *Improving partnership working to reduce health inequalities* report, this will ensure that "real engagement with practicable and sustainable outcomes" is delivered.

In summary, a partnership is:

- A sharing of skills, knowledge and resources
- A sharing of risk and reward
- Transparent to both the public and the partnering parties.

It is not:

- A short-term expedient to transfer all risks
- A way around the procurement rules
- Privatisation or surrendering of money, assets or resource to the private sector. ■

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