Launching an Academic Health Sciences Partnership in North West London

INTRODUCTION

In 2007, the first Academic Health Science Centre was created between Imperial College and Imperial College Healthcare NHS Trust. It was the first of its kind in the UK, and laid the foundations for the AHSC policy adopted by the Department of Health in 2009. That year, new Academic Health Science Centres and Partnerships were founded. Different organisations took fundamentally different approaches. Though described as different models – federated versus integrated, for example – they were in fact fundamentally different propositions. For the partnerships, the goal was to scale up on a whole population basis the evidence base for high quality care – with the emphasis as much on scale as on speed. For the integrated model, the goal was to move at pace to bring new practice from the bench to the bedside.

As part of this Review, I have affirmed the importance of the bilateral relationship between the College and the Trust, and set out a path for the renewal of the AHSC at Imperial. I believe it has a promising and essential future. Nevertheless, during the course of my Review, I have also explored the possibility of launching a new Academic Health Science Partnership in North West London. This is not about redefining the existing AHSC, nor is it about extending or opening the Imperial model to other participants. This is about launching an entirely new Academic Health Science Partnership for North West London, with equal shares and equal power for all. The goal is to improve the health and care of the whole population of North West London – some 1.9 million people.

Reflecting the voluntary and collaborative nature of such an enterprise, this paper does not seek to impose a model defined by Imperial on to other healthcare and academic institutions in North West London. Rather, it acknowledges the enthusiasm to work with one another, defines a set of principles on how we could work together, and charts a path forward. I look forward to discussing its contents with leaders in the NHS and academe in the weeks and months ahead.
1. THE CASE FOR AN AHS PARTNERSHIP IN NORTH WEST LONDON

Over the past three months, I have been fortunate to engage with the leaders from across the NHS in North West London, to discuss how our organisations can work together in the pursuit of higher quality care for patients. What I have found is enormous appetite to launch a new Academic Health Sciences Partnership.

The purpose of such a partnership is the pursuit of innovation and improvement at scale. Today, it takes too long for the evidence created by research to be translated into routine clinical practice. The Partnership will act as the mechanism for the leadership of all parts of the NHS and health-related academic institutions to come together and to work together to meet our common challenges and systematically implement what is known to be good clinical practice. This could become the place to implement innovations in service delivery – such as integrated care – or to work together on improvement initiatives so that we deliver high quality pathways consistently. It would present great opportunities to deepen and widen the development and application of research, bringing to bear the research capabilities and infrastructure of leading academic organisations. Finally, bridging the higher education and health sector, there is a compelling case for the Partnership to take a leading role in education and training – medical and other professions too.

The rationale for such a partnership is strong. Each partner bring unique and distinctive capabilities to the wider collaboration (e.g., specialist services). Second, an open and inclusive partnership means that we can take a population approach to health, having an impact on more people, and ensuring they experience the benefits of innovation and improvement in the quality of their care. Third, a large population unlocks new opportunities in research. Fourth, a larger, more diverse population together with a broader group of providers and academic institutions implies richer teaching opportunities – and the potential to take on a more substantial role as even the commissioners of education and training. And finally, bound together in a common brand means every partner has a stake in raising the performance of one another.

For our academic partners, there is a compelling case for participation in such a partnership. The AHSP would enable population-based research; it would facilitate the conduct of clinical trials at scale; it would enable applied research in the adoption of innovation in service redesign; it presents an opportunity to see the evidence-base translated into practical pathways for patient care – and for the impact to be researched. Furthermore, the Partnership may be an opportunity to access new funding streams from industry and elsewhere, or to capture synergies across organisations for procurement.

Other Academic Health Science Partnerships in London – such as UCL Partners and Kings Health Partners – have taken the name of the leading...
academic institution in their partnership. As a working title, therefore, I propose that the Academic Health Science Partnership in North West London be known as ‘Imperial Health Partners’. In North West London, we are fortunate to possess the depth of clinical talent and true excellence that could be world leading. If we are able to capture the fullness of the opportunity that stands before us, then we would create a brand or franchise with the potential for both national and international recognition.

Our high aspirations for the Partnership must be met by a determined focus on the impact that we achieve. Our Partnership must be the generator of knowledge capital, consisting of human capital (new knowledge, skills, ideas and practices), social capital (new relationships, reputation, and trust), and structural capital (new organising structures, routines, documents and tools). It will be necessary to track and measure what activities the Partnership undertakes, what that enables it to produce, and what realised value is created in terms of better outcomes for patients, more productive uses of public resources, and transferable lessons for other health providers in this country and overseas.

As I have engaged with leading stakeholders across North West London, and reviewed the available evidence, I have found that our high aspirations must be joined with a set of principles to which we can all subscribe. These should be taken as the starting point for discussion as proposals for a Partnership are developed in detail.
2. PRINCIPLES OF THE ACADEMIC HEALTH SCIENCES PARTNERSHIP

The principles that I have identified are the following:

a. Voluntary and inclusive
b. Pragmatic and programmatic
c. A foundation for collaboration, not a limitation.
d. Collaborative and equal
e. Light touch but real

I will expand on what is meant by each of these principles in turn.

a) Voluntary and inclusive

The Partnership must be voluntary. No organisation can be compelled to be a part of a partnership, and there can be no sanction for non-participation. This is both true for the membership of the Partnership overall as well as involvement in its activities. The Partnership will have the power to convene NHS leaders and to pursue specific projects, but it cannot impose upon its members. We all come to the table of a voluntary basis, and participate on that same basis too.

I have heard many perspectives on whether the Partnership should be an inclusive and open to all or an exclusive club only open to a few. I believe that in diversity we will find strength: bring the best talents of all to the Partnership. For that reason, I believe that we should be as open and inclusive as possible. I therefore propose that the Partnership is open not only to all secondary care providers, but to primary care, community care and mental health too. From academe, the Partnership should be open to all health-related academic institutions in North West London.

With the exception of primary care, it is clear that it would be NHS organisations and academic institutions within North West London that would come together to join the Partnership. The unique, autonomous nature of primary care implies a different challenge. As independent contractors to the NHS, there is no wider corporate structure to the provider-dimension of primary care. By its nature, an Academic Health Sciences Partnership is a provider initiative. It is important that the Partnership does not become a forum for commissioner-provider negotiations. For that reason, I do not believe it is appropriate for Clinical Commissioning Groups to participate. And Local Medical Committees have a specialised role on a statutory footing, making them an inappropriate body to join too.

I believe that the newly-launched Integrated Care Pilot in inner NWL may provide an appropriate structure for the participation of primary care. Participants in the pilot have clearly demonstrated their interest in working innovatively across North West London – with acute hospitals, community
services, mental health, and social care – and have formed into Multi-Disciplinary Groups at a local level. These structures are GP-led. I therefore propose to explore using the integrated care pilot structures as the mechanism to ensure primary care participation in the Partnership. With work underway to prepare an Integrated Care Pilot for outer NWL, I believe that these structures are capable of providing an appropriately inclusive provider-side GP representation.

I have not heard a consensus on the participation of social care in the Partnership. Whilst there is a compelling case for the inclusion of social care in integrated care initiatives, I have also heard the view that including all local authorities in the Partnership would add further complexity. I would propose that the Transitional Partnership Board (detailed in Next Steps, below) consider the issue and determine whether or not to extend an invitation to those organisations.

Finally, it will be important for the partnership to define its relationship with the existing institutions and frameworks for the promotion of innovation and education and training. These include (but are not limited to) the Biomedical Research Centres and Units; the CLAHRC; the HIEC; the newly-forming Health Education England and Local Education and Training Boards; and the Deanery.

The specific organisations that have expressed an interest in joining the Partnership are listed in the section on next steps, below.

**b) Pragmatic and programmatic**

The Partnership should be about making real, practical improvements to the quality of care received by patients. In this respect, it must be pragmatic rather than theoretical, focused on the pursuit of real projects whose impact can be tracked and measured. Specifically, this means the adoption of evidence-based good practice systematically across members of the Partnership. The Partnership should measure its success by the successful implementation of its programmes i.e., where it creates value in the health system for the population of North West London.

The Partnership must define a work programme that builds on the capabilities of its participating organisations. If it is to have meaning for specialist partners, clearly its programmes must include activities relevant to them. At first pass, it would seem logical to believe that areas of interest should include:

- **Integrated care**, as an area of interest to all the providers in the Partnership, and the way in which they collectively come together to improve the quality of care received by the population as a whole;
- **Cancer**, as an area of special interest to ICHT and others;
- **Cardiovascular**, as an area of special interest to the Royal Brompton and to others;
- **Women and Children’s**, as an area of special interest to Chelsea & Westminster and to others; and
- **Mental health**, as an area of special interest to West London Mental Health Trust and CNWL Foundation Trust, as well as to all other providers.

It is essential that this list is not seen as in any way definitive. It should be the starting point for discussion, not the final verdict on what the new Partnership should do. There will undoubtedly be other programmes that should be developed. Furthermore, under each of these ‘headings’ it will be important to develop a specific programme of activities and initiatives that lead to real impact. Each initiative should actively tracked, measured and managed to ensure that Partnership achieves its goals and represents good value for money.

Around each of these areas, I propose that “Clinical Academic Groups” are formed. These groups would bring together all of those from across the Partnership that have an interest in the particular area, including clinicians, academics, and clinical academics. Each of these Clinical Academic Groups would have a Chair appointed by the Partnership Board through an open and transparent appointments process, with any organisation able to propose an individual to be a Chair.

In order to make change happen, each Chair would be assigned three PAs to use to promote innovation within their CAG, in addition to support from the central team. The Chair would be able to appoint Deputy Chairs, subject to Board approval. The Chair would be required to prepare a three-year programme defining the CAG’s priorities and approach, an annual operating plan describing how the CAG would make progress towards its goals and the resources it requires, and an annual report accounting for their activities, impact, and expenditure. This would need to be aligned to the overall strategy for the Partnership, which would be the responsibility of a core team.

c) **A foundation for collaboration, not a limitation**

By convening the healthcare and academic leadership of North West London to work together on common programmes, the Partnership will be a foundation for collaboration. Yet it should not be a limitation either. Some partners may wish to go further and faster, to pursue deeper collaboration. The Partnership should have the flexibility to accommodate this, and not regard the actions of a few as inimical to the interests of others.

There is a spectrum of collaboration upon which each organisation can choose to act; there is no implication that one is better than another, nor that there is a transition to be made between different parts of the spectrum.
- **Collaboration.** Partners identify opportunities to collaborate on joint projects, leveraging the expertise of each organisation and the learning the lessons of implementation from one another. For example, this could include the systematic implementation of best practice care pathways – to the advantage of all. No revenue or capital assets are shared; the principal value created is know-how.

- **Joint venture.** Partners decide to form a new joint venture together, jointly investing in a new service or service model. Typically, equal shares in joint ventures are more successful that those where one organisation dominates. Such a venture requires investment from Partners, and thereby implies some risk – as well as reward.

- **Strategic alignment.** Partners collaborate at a strategic level to determine who should do what. Taking a dispassionate assessment of their strengths, weakness and capabilities, they make a determination on which organisation should operate at scale, and which should not. As a consequence, and on a voluntary basis, services can be reconfigured overtime.

- **Concession.** Partners decide to fully leverage the capabilities of others by handing over the management of services or facilities to other Partners who have greater strengths in a particular field. Under this model, revenue is reallocated from one partner to another, whilst capital assets remain as fixed.

- **Integration.** Partners act as a single, seamless operating entity (either by service line, or for a whole institution). Revenue lines are merged, and Partners share in any profits. They are able to deploy resources to maximum efficiency; they can rationalise their asset base to maximise its effectiveness. This would imply a single service across multiple sites and participating organisations.

These are examples of the different models of creating value within a partnership. Each individual organisation will need to decide how it wishes to work with other organisations. The Partnership provides the place for the leadership of NHS and academic organisations across North West London to come together and to begin the discussion on the best way to work in the future.

Furthermore, the partners may wish to identify further opportunities to collaborate. For example, deeper collaboration in either the commissioning or provision of education and training.

**d) Collaborative and equal**

I have received legal advice on the appropriate model for the Partnership. In common with other AHSPs, I believe that we should follow the corporate model. This is where a new company limited by guarantee is established, with each of the members of the Partnership taking shares in the company. (It is,
perhaps, worth noting that ‘partnership’ is a colloquial term; it is not possible under English law to have partnership without a profit motive).

Each member of the Partnership should have an equal number of shares in the newly-formed company. Equal shares must mean equal power within the entity – and equal responsibility for results.

e) Light touch but real
Observing the activities of other AHS partnerships, each has an annual budget of approximately £3 million. This is used to finance the appointment of a Chair, a Chief Executive, and a small management team of senior health service managers, capable of making change happen in a multi-stakeholder setting, where the ability to influence and persuade are essential.

In addition to the appointment of a Chair and a Chief Executive, it will be necessary to create other posts consistent with the Partnership’s mission. These might include a Director of Clinical Quality and a Director of Education and Training. The quality improvement, research, and education and training agendas will require considerable coordination and appropriate resources to undertake this. Furthermore, each of the programmes will need to have individual project managers and project teams put in place to ensure that the priorities of the Partnership are successfully implemented.

The financing of the Partnership should be through the setting of a budget (within the range of £3-5 million annually) and each institution paying an annual subscription. Having discussed funding with chief executives, I have concluded that to maintain parity of power between participating institutions, each should contribute a fixed sum to the Partnership. This will consist of the annual budget divided by the number of members. For primary care, I propose that the NHS London or NHS North West London are approached and requested to finance their contribution. Furthermore, the Partnership should actively seek additional resources, e.g., accessing monies held for innovation by NHS London, the Department of Health, industry and the private sector, and philanthropic sources.
3. NEXT STEPS

I have heard the significant appetite that there is to pursue greater partnership together. Inclusivity has become the watchword of innovation – a greater number of partners enabling creativity to be sparked from one another, and the formation of virtuous circles where success inspires success. As we look to other Academic Health Sciences Partnerships, close by such as UCL Partners or further afield such as Partners HealthCare in Boston, it is clear that programmes that seek to collaborate across multiple organisations have much to offer. There is great, untapped potential that exists in the enormous depth of clinical and research talent across our part of London.

I have also heard the clear message that the landscape of innovation and improvement has become increasingly busy with different structures and mechanisms. At a minimum, these should be aligned; they may even be rationalised. It will be for the Transitional Partnership Board, consisting of chief executives, to determine what steps they wish to take in this direction.

Transitional Partnership Board

I propose that a Transitional Partnership Board is established with the task of preparing a compelling and detailed proposal for the Partnership, taking the principles that I have described here as a starting point for discussion. This Transitional Partnership Board must:

■ Confirm the membership of the Partnership, based on the membership proposed in this paper, and the voting arrangements and Terms of Reference for the Partnership Board;

■ Define the programme of projects for the Partnership in its first year, with an outline of the resources required and identified project leads at an institutional level;

■ Agree the organisational structure for the management team of the Partnership, and hosting arrangements for this team (e.g., where physically the team will be based);

■ Define the role and job description for the Chair and Chief Executive of the Partnership, and form an Appointments Subcommittee to guide the process of appointment, once the Partnership is agreed by the various boards;

■ Agree the proposed financing formula and agree the budget for the first year of the Partnership; and

■ Confirm the proposed legal model and instruct lawyers to create a new Company limited by guarantee.
Membership of the Transitional Partnership Board

Following extensive engagement across North West London, I am pleased to confirm that the [NAME OF THE BOARD CHAIR] has agreed to Chair the Transitional Partnership Board, and that the following leaders of the NHS and academic sectors have consented to membership of the Board:

1. Sir Keith O’Nions, Rector, Imperial College
2. Mark Davies, Chief Executive, Imperial College Healthcare NHS Trust
3. Heather Lawrence OBE, Chief Executive, Chelsea and Westminster NHS Foundation Trust
4. Robert Bell, Chief Executive, the Royal Brompton and Harefield NHS Foundation Trust
5. Julie Lowe, Chief Executive, Ealing Hospital NHS Trust
6. David McVittie, Chief Executive, The Hillingdon Hospitals NHS Foundation Trust
7. Peter Coles, Interim Chief Executive, North West London Hospitals NHS Trust
8. Dame Jacqueline Docherty, Chief Executive, West Middlesex NHS Trust
9. Peter Cubbon, Chief Executive, West London Mental Health Trust
10. Claire Murdoch, Chief Executive, Central and North West London NHS Foundation Trust
11. Dr Andrew Steeden, GP Co-Director of the Integrated Care Pilot
12. James Reilly, Chief Executive, Central London Community Healthcare
13. Richard Tyler, Chief Executive, Hounslow and Richmond Community Healthcare NHS Trust

I am grateful to each of these individuals for the leadership they have shown by agreeing to make a contribution to the further development of the proposals for ‘Imperial Health Partners’.

Timetable

The goal will be to launch ‘Imperial Health Partners’ on 1st April 2012. The purpose of this Transitional Partnership Board, therefore, is to develop detailed proposals for ‘Imperial Health Partners’ to be presented for approval by the individual boards of participating organisations by the end of January 2012. This will leave eight weeks for legal incorporation and the appointment of an executive management team.

This timetable is ambitious. I therefore propose that the Transitional Partnership Board meets once in November, once in December and once in
January. It will also be necessary to resource a small team to support the Transitional Partnership Board; for that reason, I would request each of the institutions involved to put forward £10,000 towards the further development of this effort. I will be engaging with NHS London and NHS North West London to request their support for this process too.

CONCLUSION

This is precisely the right moment to pursue such an ambition. This is a time of great turbulence for both the health and higher education sectors. Budgets are under significant pressure. The NHS faces a stark choice: it can either return to what it knows best, incrementally reducing services and allowing waiting lists to grow, or it can embrace the transformation of health services for the population. Academe faces a funding abyss in which the quality of its output must shine brighter than the heights of its fundraising capability. This implies an important choice for all NHS and higher education organisations in North West London: do they face the storm alone or standing in solidarity? And if the latter, what does this mean? It seems that the best each organisation can offer is a sharper focus on its strengths, greater specialisation where it excels, by coordinating more closely with its partners.

Finally, as I outlined in Healthcare for London and in High Quality Care for All, I believe that academic health science centres can become the cornerstone of our NHS system, delivering the quality of care to which we all aspire. For that reason, I believe that it is essential that steps are now taken to launch a nationwide Academic Health Science Network that brings together all of the existing Academic Health Science Centres and Partnerships. Furthermore, I believe that we in North West London should aspire to push the concept even further, and set ourselves on a journey towards an Academic Health Science System that brings together the very best of the NHS, academe and industry.

Together, we face common challenges and could cooperate to achieve so much more together than we can do apart – improving the quality of care for our population as a whole, creating a richer and more rewarding professional experience, and reinforcing our institutional foundations by capturing the scale economies that exist through working more closely with one another.

I look forward to the launch of the Partnership in 2012.

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