# Academic Health Science Centres in the UK

**Peter Ellis**

**People in Health**

**pellis@peopleinhealth.com**

**www.peopleinhealth.com**

**+44 (0) 7785500384**

## Contents

## 1. Context

Situation

The aspiration in major academic health science centres (AHSCs) worldwide is threefold:

- The creation of new knowledge to improve health
- The use of new knowledge in optimising health care and clinical outcomes
- The dissemination of new knowledge among students, trainees and staff and the health system at large

Within the UK the creation of AHSCs would provide the opportunity to be the innovation hubs for the whole system of health care delivery within the UK. Either through direct control or through its influence, an AHSC can be the leader, within a region of the broader health system.

The required co-ordination and integration of clinical services, research and education is not easy to achieve. Each of these functions has unique capabilities, culture, governance and management structures and financial arrangements. The benefits of aligning these components far outweighs the effort required to overcome the enormous political, cultural and management resistance to the loss of autonomous action that integration requires.

AHSC can aspire to a narrow role focussing on leadership in a specific disease entity e.g. cancer or assume a broader regional role as the leader of a comprehensive academically based “health system”.

The challenge is to create an entity that can deliver on these goals and thereby return the UK to a globally recognised player in healthcare innovation and return it to offering standards of care that equate with the worlds best.

This will be achieved by developing a solution that provides the necessary freedom of action within an existing regulatory framework that can align the clinical and academic resources

Implications of Integration

Successful integration between academic hospital trusts and universities will require a strong will to overcome the many real and perceived barriers. However, it is not difficult to justify a model that, while assuring exemplary health care to the population will also generate significant health and economic benefits to the nation greater than the sum of the parts.

This does not come without risk to all parties:

- For the university assuming some financial risks and responsibilities for heath care service and facilities
- For the NHS entrusting delivery of health care to a third party it does not directly control

These organisations cannot be created without broader change within the NHS. The DH’s emerging recognition that “one size fits all” is not going to carry this system forward in the long term. The way these concepts are presented will be as important as their reality

There is a continuum of approaches to provide varying levels of partnership and integration. These are shown below in an escalating order of difficulty to achieve, with concomitant associated benefits:

- **Virtual Organisation**. – This relies on electronic links and communication to bind together a variety of enterprises. An example would be national research consortia that bring together a geographically spread group of universities, research institutes

and trusts linked by a single grant and shared research goals and information resources.

- **Co-location.** – This physically locates various functions in proximity to each other. It allows regular interaction between the parties and benefits from the horizontal proximity of the respective facilities. In this model the so called "white coat distance" which allows people to move between clinical, educational and research functions without having to change into outdoor clothing, is recognised as a crucial element.
- **Coordinating Mechanisms** – This establishes a "joint conference committee" to coordinate activities between the parties. Each entity remains independent with individual structures
- **Delegated Authority –**This would delegate to the board of an entity responsibility and resources to manage as a single organization. Representation at board level and integrated management structures aligned to the core purpose would be implemented.
- **Joint Ventures**. – This establishes a formal jointly owned entity that manages all or particular functions on behalf of the founding partners. It would normally have committed aligned funding integrated structures and a common set of objectives and performance criteria.
- **Merger.** – This is highest level of integration which consolidates the assets and resources of the partner organisations into a single entity. It implies common governance and a single vision, purpose and shared resources

The first three of these options are seen as more tokenism than achieving truly aligned purpose.

Successful models from other jurisdictions

Across the globe there are a variety of models that have been developed to achieve the goals of integration. The structures in many ways reflect the culture and societies in which they exist. There are however aspects and approaches that both legally and culturally are worth considering. Appendix 1 shows some examples from other jurisdictions. Successful AHSC have certain common attributes which ensure that there are robust mechanisms for alignment of purpose and integration of the governance leadership and programmes of the entity. Thus the first three options above have not demonstrated that they can effectively achieve the desired goals.

UK Relevant Solutions

The preferred model should be premised on allowing autonomy and fostering creativity. It should reward and recognise the unique governance, structural and resource challenges of the hospitals and their respective university which have major academic missions and purposes. Discussions within the DH have indicated that an innovative model which may require innovative use of existing legislative frameworks would be considered. The criteria must allow establishment of AHSCs without the need for new legislation.

The Options available include:

- Limited university involvement through representation on the board of an NHS trust and joint leadership of major programmes
- An "Academic" NHS Foundation Trust applied for under section 33 of the NHS Act 2006, by the trust with significant involvement in the governance and management the university
- A university sponsored NHS Foundation Trust (FT) created under section 34 of the NHS Act 2006, which can be initiated under the designation powers of the Secretary of State
- A university owned entity which has leased to it, in perpetuity, the relevant hospital and healthcare facilities
- A separate not-for-profit corporate body, , to which is devolved the relevant clinical and academic resources of the University and the Hospital Trust

If a section 33 application to Monitor was unable to provide satisfactory governance and management arrangements, (The limiting factors could be flexible governance and management arrangements and the private activity cap on FTs based on founding trusts past practise) then further more radical options could be pursued through an application to Monitor for NHS FT designation under Section 34 of the Act. In all cases the sponsoring Applicant would remain accountable to the University for the HEFC funding and other external University channelled resources.

If a section 34 NHS foundation Trust were established for the purpose of being an Academic Health Science Centre, the Secretary of State has the power under section 56 of the NHS Act to effectively merge or transfer into it existing NHS trusts thus ensuring continuity in the handling of personnel and property ownership.

It is important to note that there are various options under which corporate entities can operate under a variety of regulatory frameworks. These are detailed later in this document. Preliminary discussions with Monitor had indicated an interest to work towards a model for an Academic Foundation Trust that would meet the required objectives of an AHSC in the UK.. Monitor has yet to develop proposals for the criteria to be used in a section 34 designation. It is assumed the schedule 7 requirements would still be built in to the constitution.

Creating an effective Academic Health Science Centre within the UK context

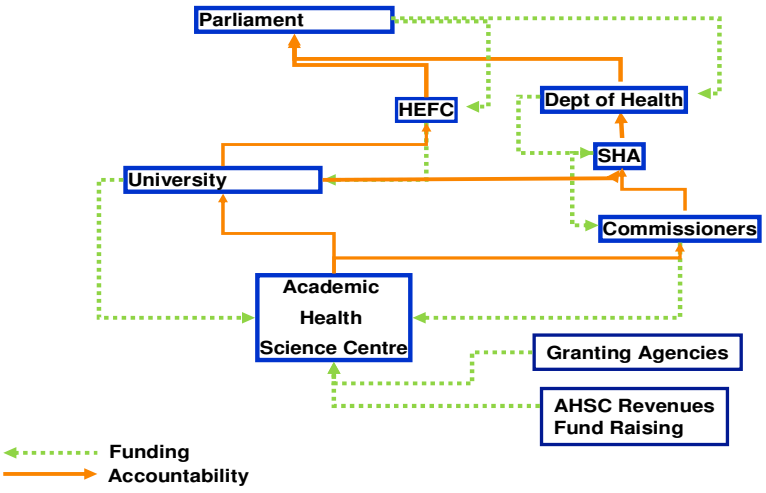
The need is to create a new and innovative entity with aligned governance, purpose, authority, structure and resources. The further challenge is to align its structures and resources to create a dynamic organisation that will be greater than the sum of its parts and in doing so bring added stature, kudos and benefits to the academic and healthcare systems.

An AHSC could feasibly work under two distinct accountability structures whether the entity is working under the NHS regulatory framework or that of the Independent regulator, Monitor.

An NHS Trust based AHSC or a University created subsidiary body, which acted as a contractor to the NHS, would have similar funding and accountability structures as follows:

**Academic Health Science Centre Criteria**

**Accountability under 2006 Act and SI 2001 No 3968**




Peter Ellis
May 2007

A university could work with a Trust(s) to promote an AHSC with revised governance and management structures initially operating under the NHS Trust legislation and then seek through Monitor special designation as an Academic Foundation Trust. This would require particular flexibility and cooperation of the appointments commission in the make up of the

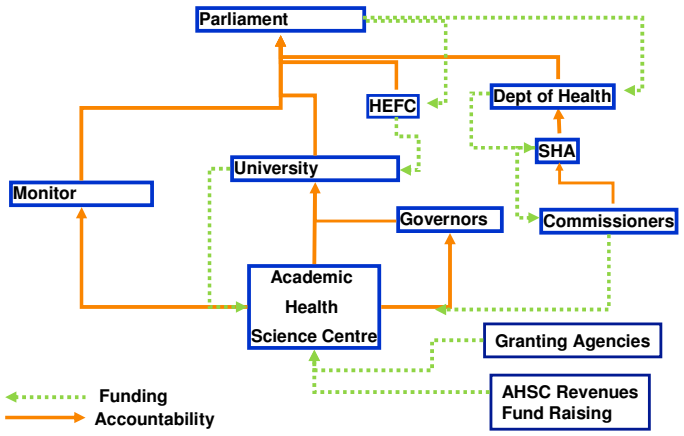
Board of Directors. In the spirit of the concept of an AHSC the Board of Directors and Chair would need to be appointed, with the support of the university.

In advance of achieving FT status an "Advisory Council" reflecting the various stakeholders including academic institutions, regional develop agencies and national patient and research bodies should be established as a precursor to having Governors/Members

An AHSC could also be established by a university sponsored applicant (possible subsidiary) applying under section 34 of the NHS Act or be party to an NHS Trust application under section . The regulatory and accountability structure is as follows:

**Academic Health Science Centre Criteria**

**Accountability under 2006 Act FT (section 33 or 34)**




Peter Ellis
May 2007

In this situation the university would work with a Trust(s) to promote an AHSC with revised governance and management structure and seek through Monitor special designation as an Academic Foundation Trust. This would require particular flexibility in the make up and appointment of the Governors and the Board of Directors as required under schedule 7 of the NHS Act.

The key to this model is the creative use of the Governors component within an Academic Foundation Trust Model. We would see the university nominate members along with representatives of national research and patient Interest groups such as MRC, Heart and Stroke Foundation, CRUK etc. It would also have PCT, LA, and academic and healthcare staff reps as required. The Board of Directors appointed by this body would be a mix of executives, non executives and independents in line with code of governance requirements. Through the university's role in the Governors they would influence the appointment of the Chair and CEO unless there was specific provision in its charter.

If this approach through a section 33 or 34 application to Monitor was unable to provide satisfactory governance and management arrangements, further more radical options could be pursued with the independent AHSC as an NHS contractor. In all cases the university would still remain the accountable body for the HEFC funding and other external resources. These models could be one or a combination of the following:

- The Trust is dissolved and the university has leased to it, in perpetuity, the relevant hospital and healthcare facilities by the DH (Ownership Model)

- A university owned subsidiary corporation, to which is devolved the clinical and academic resources of the university and the Hospital Trusts. This corporation could be any of the following:
    - A Community Interest Company
    - An Industrial Provident Society
    - A Company limited by guarantee
- In all the above corporate structures the entity can operate either under the same regulation as an ISTC or other contracted bodies

If application is made as a university sponsored Academic Foundation Trust Hospital initiated under the section 5 designation powers of the Secretary of State (the university-AFT Model) the resulting corporate entity would be a "public benefit corporation"

The options can be shown as follows in respect to the corporate structure and the options for differing regulatory frameworks.

**Academic Health Science Centre Criteria**

**Effective alternative options**

| **Corporate Structure** | **Regulatory Framework** | | |
|---|---|---|---|
| | **NHS Act 2006 NHS Trust** | **Contractor SI 2001 No 3968** | **NHS Act 2006 FT section 33 and 34** |
| • *Academic Health Science Centre as NHS Trust* | • Co-operation of Appts Commission if NHS Trust | | |
| • *Academic Health Science Centre as Public Benefit Corporation* | | | • Monitor flexibility with Governors and Board appts under section 33 NHS 2006 act |
| • *College Owned/Sponsored* | | • Companies Act Contractual relationship as per ISTCs | • Sec of State supported application under section 34 of NHS 2006 Act |
| • *Community Interest Company (ICL sub)* | | • Companies Act Contractual relationship as per ISTCs | • Sec of State supported application under section 34 of NHS 2006 Act |
| • *Mutual/Provident Society (ICL sub)* | | • Industrial Act and Provident Societies Contractual relationship as per ISTCs | • Sec of State supported application under section 34 of NHS2006 Act |
| • *Corporate entity limited by guarantee (ICL sub)* | | • Companies Act Contractual relationship as per ISTCs | • Sec of State supported application under section 34 of NHS 2006 Act |

Peter Ellis
May 2007

In any of the proposed models the Academic Health Science Centre would be resourced and managed to undertake all strategic and operational activities on behalf of the parties as it relates to activities within the its responsibility. This includes:

- Clinical Programmes
- Translational and discovery research
- Clinical Research
- Health Services Research
- Clinical Epidemiology
- Health Economics
- Under graduate and post graduate education

- Technology Transfer
- Start up investments

Further, the parties would put in place programme development mechanisms to oversee strategic direction and fund raising etc. Processes would also be agreed to ensure joint appointments in all key clinical and academic positions.

Biosciences Business Park and Incubators
As previously stated a critical mass of scientists and innovation potential attracts industry and investment. The AHSC needs to demonstrate commitments and structures to enable partnering with other adjacent research institutes, the pharmaceutical industry, established Biotech companies and the medical device sector. It will also be possible to consider establishing a bio incubator to nurture the development of innovative technology, products and companies. The AHSC would require strong links and alignment with the RDA's strategy for the region

## 2. Criteria for Effective Governance and Management of an AHSC

The determination of whether an entity has the specific commitment to achieving its mission as an AHSC will be demonstrated through its creation of aligned and effective governance and management functions and structures. It is essential that these be aligned to the purposes and aspirations of the centre, or as required by monitor reflective of the "goods and services being offered. Many examples exist of mergers that have collapsed or failed to achieve their goals because the structures and management arrangements were not focused on the core purpose or were too slow in being implemented to capitalise on the opportunity to achieve real change.

As stated earlier, AHSCs can be focussed on single disease entities or the leadership of a health system involving a myriad of providers, in all cases the development of appropriate and effective governance and management structures will be fundamental to the entity's success.

The structures suggested below, while not necessarily the most elegant, have been designed to make the most of the available options under current political and legislative realities. It is also believed that they offer the opportunity to be implemented relatively rapidly to harness the commitment and momentum for such an initiative.

Governance Structure
The success of the enterprise will initially be dependent on a governance structure aligned the organisation's mission culture and values committed to meet its obligations and ensure it complies with corporate governance standards. This structure will require a membership carefully aligned to the Centres mission. The membership should be an appropriate mix of commercial, clinical and academic competences. In accordance good governance principles, all members once appointed to the Board of Directors will recognise their primary obligation while participating in the governance of the entity is to its overall best interest.

The AHSC can be created within existing NHS legal structures. The eventual goal will be to be an "Academic" NHS Foundation Trust; however operation as a single merged entity under the current NHS Trust corporate arrangements will still enable the creation of an AHSC

The Board of the AHSC could be established within the existing NHS Trust regulations to reflect the organisation's mission as an AHSC. It is believed this can happen with the co-operation of the Secretary of State and NHS Appointments Commission. This governance structure along within the combined management and clinical/research leadership will allow the centre to pursue its goals.

It is important to create the culture and attract the right competencies required for the Board which require experience in:

- managing a complex organisation;
- ensuring exemplary patient care;

- building an international leader in research and education;
- exploiting commercial capability to its full potential;
- attracting and managing significant resources from the government and private sources;
- promoting the institution as a world recognised brand associated with quality of care and excellence of its science;
- providing confidence to the regulators and funders, thus allowing it to take risks in the pursuit of its goals; and
- leveraging the university's credibility and experience to raise funds, build alliances and spin-off businesses.

The Transition from NHS Trust to Academic Foundation Trust Status
Prior to achieving FT NHS Trust status an AHSC would be advised to operate with the culture of an FT Board thereby demonstrating it can mange the risks inherent from the freedoms that FT status endows on them.

In advance of achieving FT status the AHSC should consider the establishment of a body equivalent to the members/governors of an FT. As previously stated this could be in the form of an "Advisory Council" reflecting the various stakeholders including academic institutions RDAs and national patient and research bodies.

Membership/Board of Governors

The main changes are how the Board is appointed and the establishment of a membership and Board of Governors.

- The Board of Governors consists of elected and appointed members and varies in size from 18 to 50 people at current FT's.
- The Governors act on behalf of the members of the corporation.
- The role of the Board of Governors is fourfold:
  - advisory;
  - guardianship;
  - whistle blower for noncompliant behaviour; and
  - strategic – advising on a longer term direction for the NHS FT.

As an AHSC the goal is to create Governors who represent the full cross-section of community and stakeholder interest. Constituencies will have to be defined for both local and national clinical services, and the research and education mandates. The process by which the Governors are appointed will need to be agreed and demonstrated as transparent and in the case of some representatives, elections have to be held. A suggested make-up is shown below. This is intended to bring in the national and research and education interests through national disease oriented associations that are aligned with the AHSC's major programme foci.

- *Staff:*
  - *Medicalx2*
  - *Nursingx2*
  - *Professionalx1*
  - *Ancillaryx1*
  - *Volunteersx1*
  - *Studentsx1*
  - *A&Cx1*
- *Public/Patient:*
  - *General from Catchment areas x5*
  - *Programmes x6*
    - *CRUK*
    - *Stroke Foundation*
    - *Diabetes Assoc*
    - *HIV Assoc*

- *Public Health*
- *RA Society*

- *Related Organisation*
  - *PCT reps x5*
  - *Local Authority x2*
  - *MRC*
  - *Wellcome*
  - *NIHR*
  - *Major University Partner x 3*
  - *Other Affiliated Universities*
  - *Industry*
  - *RDA*

Total 35

Special recognition as National entities to act as proxy's for patients in a "national constituency" would be required from Monitor

In developing the actual governance and membership structures, the AHSC will work with other local partners (PCT's, L.As, etc.) to develop a structure that is sensible to local commissioning and partnership arrangements.

Board of Directors
The Board of the AHSC will focus on the delivery of healthcare services, research and teaching rather than traditional NHS structures that are primarily service oriented. Thus, the suggested Non Executive and Executive members of the new entity would be different from the typical NHS Trust structure:

Suggested Membership of an AHSC Board:

- Board Chair;
- The Centre's Chief Executive;
- The Centre's Director of Finance;
- One Representative Faculty of Medicine (Dean)
- Registered Doctor (could be programme director;
- Registered Nurse; (could be professional leader)
- University Vice Chancellor or representative (non-executive);
- Six/Seven Independent non-executives nominated by Governors and University through recognised appointment process to attract the best candidates with the credentials to provide effective governance to a >£850m operation. [1];

**Academic Health Science Centre Criteria**

**Illustrative example of AHSC composition**

| | Exec | Non Exec | By virtue of office | No Affiliation |
|---|---|---|---|---|
| **Board chair** | | √ | √ | |
| **CE** | √ | | √ | |
| **Director of Finance** | √ | | √ | |
| **Vice Chancellor (or rep)** | | √ | √ | |
| **Medical Director** | √ | | √ | |
| **Faculty of Medicine(Dean)** | | √ | √ | |
| **Director of Nursing** | √ | | √ | |
| **7 Independent Directors*** | | √ | | √ |

*NHS Trust has limit of 12 + Chair, FT governace code requires No. of Independent Directors equal to all others

Peter Ellis May 2007

It is important to differentiate clearly between the Independent (i.e. no affiliation), Executive and Non Executive membership the above schematic illustrates this.

With regards to independent directors on the Board, the University would use its influence and credibility to assist in attracting the highest calibre of candidates. It should be noted that all Directors should be individuals whose primary goal is the achievement of the institutions purpose and should not be representative of any stakeholder or Special Interest groups.

This would result in a Board of 13-14 people

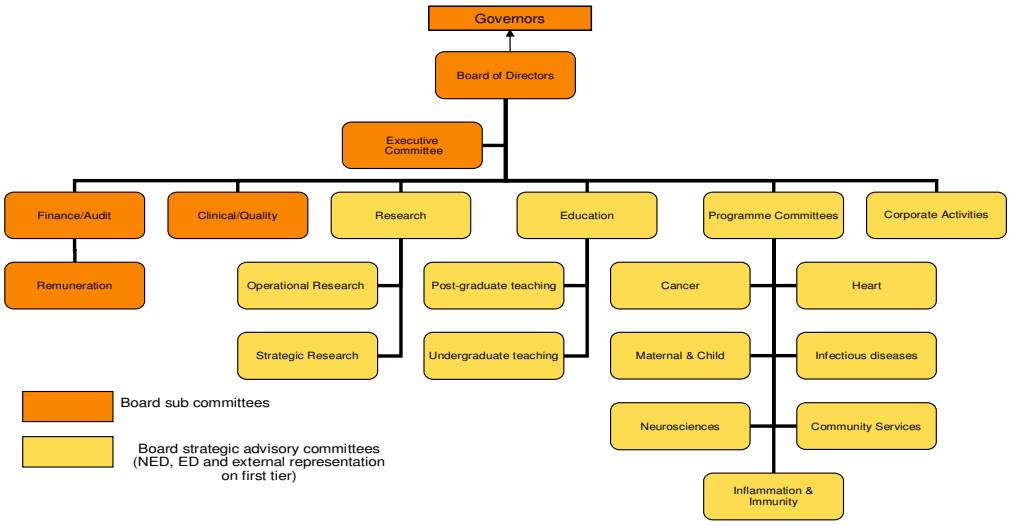
[1] Under NHS Trust requirements the Board is limited to the Chair + 12 members. Once NHS FT status is achieved the independent members have to equal the members with affiliation .

Board Committee Structure

The Board Committee Structure should be aligned to the mission of the AHSC. A typical sub committee structure would include a finance sub committee whose responsibilities would include audit and remuneration. Separate sub committees could be established for clinical services and quality, research, and education to oversee the three main strands of the AHSC's business. The primary purpose of the organisation will be achieved through the success of its declared areas of expertise, which would be organised as programmes (see below in Management and Leadership section). In order to ensure alignment of the governance to this concept programme sub-committees could have oversight of the major programme foci and could have representation from external stakeholders to ensure ongoing dialog and input from the communities and other interest groups being served.

**CHART 3 Governance Structure**

**An illustrative example of a Board of Directors structure**




An Independent Charitable Foundation Board should be set up to lead external fundraising efforts and to manage the combined special trustee resources and appropriate research endowments. The frequency and specific remit of each of these committees would need to be determined by the AHSC.

Programme Management and Leadership Structure

Much of the change in how an AHSC will be different will be in the focus and organisational structure of management and leadership of the new AHSC. As a means of bringing together the clinical, research and education components the focus will be on integrated programmes around the key themes that have been identified as current or future priority areas for the AHSC. These can be grouped as an example as below:

- Heart and Lung
- Community services
- Infectious Diseases
- Inflammatory and Immunological Disease
- Cancer
- Maternal and Child Health
- Neurosciences

Structuring these units will need to take account of their integration with the University's priorities as well as the AHSC

The key to the buy-in of the clinical, research, technical and managerial staff is that the AHSC is seen to be a new entity that will focus on the core competencies of the founding partners which would then be aligned to establish the AHSC's unique identity and culture. It should also be borne in mind that the creation of a new "global brand" may require skills and experiences that are different from those in the current organisations.

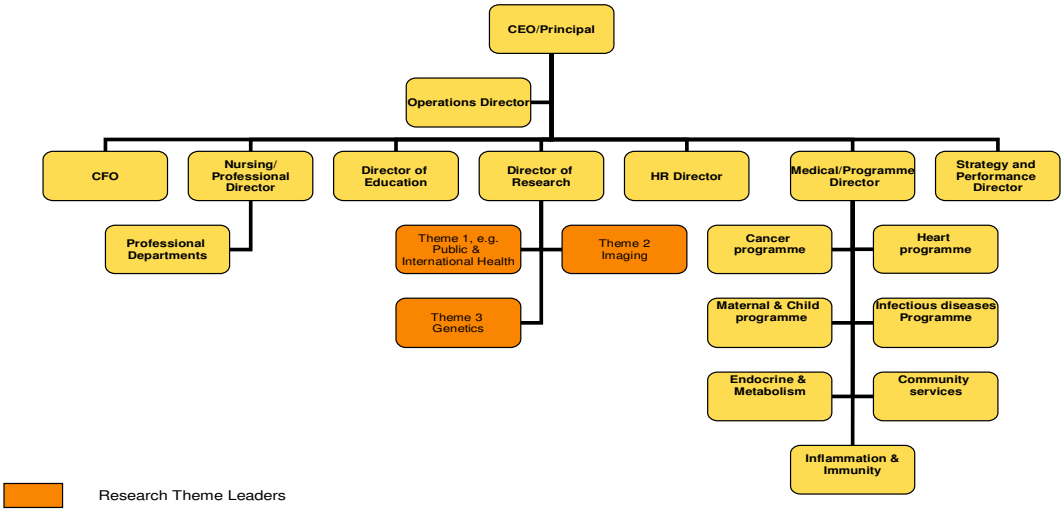
It is important to determine an overall approach to how the Centre's leadership and management would be structured to align its business, clinical and academic management to its key aspirations and programmes. Overall direction would be determined by the CEO, who would be appointed by the Board with endorsement by the University and the AHSC Governors. All the executive staff would be combined appointments and hold honorary appointments in appropriate academic departments.

The combined heads of the core programmes would be selected on leadership capability or potential in running complex multi- speciality programmes. Each such unit could be responsible for an £75-125m. operational unit.

The operation should be managed through an executive under the leadership of the CEO which would consist of the CFO, CMO, CNO, Combined Programme Heads, and other corporate functions as required

## Leadership & Management Structure

**An illustrative example only of integrated programme management structure**




Multi- Professional Approach

In addition to medicine, the other clinical support departments such as nursing, psychology, biomedical engineering, radiology, pathology, rehabilitation, and pharmacy would have to develop academic priorities. These would also be aligned to support the major programmes foci. The departmental heads would have appropriate academic cross appointments and, like the medical department heads, would be required to reshape their departments to support the AHSC 's major programmes.. Discussions will be pursued with as to the possibility of creating other health discipline programmes. These could be academically focussed Masters and PhD programmes or aligned with the business school and other faculties.

Professional and Clinical Practice Management

Medical and professional department heads would be appointed with authority to recruit and manage professional issues only. These departments should recognise their obligations to support the major programmes. Again, these appointments would be made on the basis of leadership capability as well as clinical or academic expertise.. All the departmental heads would have AHSC and University combined appointments and would have the authority to recommend academic promotion. A Clinical Practice Committee is to be established to ensure appropriate clinical governance procedures and processes

In the future more radical concepts, such as pooling of income, may be considered to allow all aspects of clinical and academic income can be managed together by the department, and individual strengths and contribution recognised.

Accountability and resource allocation
The founding partners would each be ceding authority to the new AHSC to ensure integrated accountability and effective management of resources. The NHS Trusts would be subsumed within the new governance and management structure of the AHSC. The university, however will still have a separate corporate identity and will therefore need to articulate the role and responsibilities that it is ceding to the new entity for the management of relevant academic resources. The combined resources are likely to be extensive with large AHSC's managing resources of over £1m:

The University will have to acknowledge the need to ensure delegated authority to the new entity. Their will be required a devolved financial authority structure and it will need to demonstrate a willingness to make the following assurances :

- The Dean of Faculty of Medicine and Vice Chancellors rep. as members of the board will have the delegated authority to commit academic resources.
- In line with legal accountability, the university will devolve authority and programme budget holders will be held accountable.
- The university would be willing to devolve authority for the use of the Higher Education Funding Council for England (HEFCE) funds to the new entity with the caveat;
    - that they be used for the overall purpose intended; and
    - within the framework of the agreed strategic direction.
    - The clearly designated scheme of accountability for HEFC funding will be through the University
- Grant Funds accountability will be project specific and used for such, in accordance with the funders' requirements.
- Subsequent delegation will be to AHSC programme budget holders who will be individuals with joint contracts.
- Use of funds has to be line with the University's overarching governance framework and legal responsibilities.

The articles of association will need to clearly define the Centre's independent rights of action. They will need to provide clear authority to allow:

- Physical asset disposal and development
- Acquisitions
- Equity participation
- Fundraising campaigns
- International ventures
- Use of brand

Discretionary funding will be a major opportunity for the AHSC to exploit its new capability. Most current revenue passes through accounts with little opportunity to re-direct, e.g. salaries and fixed contracts. Historically trusts have had limited access to discretionary resources. While they may seem small in relation to the overall budget, revenues derived from undesignated sources gives significant freedom for innovation and investment. In the main discretionary Resources come from, fund raising, grants, joint ventures for commercial and research purposes, spin-outs and commercial activities. The universities brand, experience and capabilities in attracting funds from non-government sources will provide an opportunity to rapidly grow this alternate income source. With FT status and the University relationship, an order of magnitude increase in discretionary resources should be achievable

The articles will need to provide for an appropriate structure allowing the AHSC to focus on commercial activity, exploit intellectual property and know how, and exploit its brand internationally.

## 3. Summary of Evaluation Criteria

As no similar organisation exists to date within the UK, it is hard for those who have not experienced the culture and environment of a similar entity in another jurisdiction to fully grasp the differences. Some may aspire to AHSC designation for purely agrandisation reasons. The designation needs to be protected to avoid the same devaluation that the “University Hospital ” and “Teaching Hospital” designation have suffered in the UK.

What would be different about how the AHSC functions

In presenting themselves as an AHSC the entity would have to demonstrate significant change in its focus accountability structures and operations. Some are significant and obvious, others more subtle. The major differences can be summarised as follows:

- Governors Structure
  - National constituencies as basis for selection (not only local)
  - Include major national bodies i.e. MRC, CRUK etc.
  - Have significant university and academic involvement
  - Includes economic interest’s i.e. RDAs
  - Recognise role of regional “health system” leader
- Board Structure
  - Presence and influence of the university officers at Board
  - Ability to attract brightest and best of Independent directors
  - Committees and business focussed on combined goals
  - Ability to generate alternative revenue
  - Board structure aligned to purpose
- Culture
  - Focus on patient care, research and teaching as integrated goals
  - Ability to use direct communication and commitment of the university to AHSC to influence new entity’s requirements from the university
  - Forum for resolution of contentious issues between University and AHSC
- More effective use of combined resources
  - Real delegation through AHSC for committed University (HEFC and Other)resources
  - ensuring maximum leverage and best use of all parties capabilities
  - Combined fund raising
  - Combined exploitation of know how and IP
- Leadership
  - Combined positions ensure key roles with responsibility for integrating managing and exploiting combined resources to achieve clinical and academic goals
  - CEO's role as influencer and relationship with University Officers
- Kudos
  - Ability to use integrated brand and recognition
  - International credibility in recruiting
  - Recognised globally and magnet for global initiative leadership
- Commercial

    - Creation of Cluster and attraction of relevant bio-science industry activity
    - Attraction of inward investment and contract research
- Alignment
    - HE and NHS funding and accountability better aligned with FT status so advantage of AHSC can be exploited
    - Joint fund raising activities

The major change for many of the stakeholders will manifest itself as a new culture for the organisation. Particularly as the centre operates from multiple sites, aspects of the historic cultures will remain but a sense of common purpose and cohesiveness will emanate from the having a shared culture that is new for all the founding partners and driven by a common vision.

Key AHSC Evaluation Criteria

1. Integrated governance, leadership and management of service, teaching and research functions. Thus both academic and health care resources should be seen to be grouped into logical cohesive business units that have clear unified leadership
2. Notwithstanding needs for dual accountability to University and NHS has integrated budgets, resource management and accountability
3. Clear accountability to funders (DH, HEFC) that meets legal obligations
4. Integrates other providers and partners in health or disease system in all aspects of activities both academic and clinical
5. Ability to hold and manage public assets and establish confidence of regulators and funders
6. Has the freedom to be able to enter into binding contracts with a variety of stakeholders including academic, health care and private sector organisations
7. Recognises the multi-disciplinary nature of health care and ensures all professions and related academic institutions play an active role in the development of the AHSC
8. Demonstrates a recognition of its broader role to be involved in health service and multi-disciplinary research and education
9. Shows ability to attract investment and borrow funds for sound business initiatives
10. Saleable to the public, PCTs etc. that the new entity is a guardian of health care delivery
11. Enables transfer of assets staff and their benefits
12. Demonstrated systems of effective clinical governance and ability to ensure delivery of HC Commission standards
13. Ensures rapid conversion to AHSC Achievable within a short timeframe and with minimum long-term disruption
14. Is able to demonstrate innovation, excellence and “can-do” attitude in its approach to creating the new entity
15. Demonstrated willingness to compete globally for resources and people
16. Recognises and builds on history and reputation of founding organisations
17. Demonstrates ability to meet and inform political and bureaucratic agendas

## 4. Appendix 1 Examples form other jurisdictions

**University Owned Health Science Centres**

These are to be found particularly in North America:

- Duke University Medical Centre, where the hospital and research institute are a wholly owned subsidiary managed directly through a University Vice Chancellor
- Sunnybrook Health Science Centre which, while the hospital and research facilities are owned by the university, are governed in perpetuatory by an independent corporation with representatives of the University, community and government through order in council appointments
- McMaster Medical Centre, Hamilton, Ontario was the first school to implement problem based learning and abolish the preclinical/clinical split in the curriculum because of its integrated existence on a single site
- The University of North Carolina (UNC) provides an example of flexible governance. The State Legislature granted UNC Health Care System a quasi-governmental legal status in order to release the system from civil service requirements, state purchasing rules, and other regulations that hindered its ability to compete (e.g., make acquisitions). As a result, UNC Health Care System has its own system board. The dean of the medical school serves as the CEO of UNC Health Care System and as a full-voting member of the system board

**Hospital Owned academic institutions**

Examples can be found in US, Canada, and The Netherlands:

- Massachusetts General has its own research institute, with a budget of $300m. It is also part of the Partners Healthcare system which is described in the Community Network below
- Mayo Clinic has its own medical school which grew out of the hospital and research institute
- Academisch Ziekenhuis Leiden (Leiden University Medical Centre) has created a single organizational entity for the hospital and medical faculty governed by a single Board
- Toronto General Hospital has its own wholly owned research Institute which attracts $90m in peer reviewed funds. A new 1.5 m sq ft Bioscience centre has recently been completed on their site

**Joint Governance Alliances**

- University Medical Centre Utrecht. Regulations preclude the hospital owning a degree granting institution and they have therefore appointed parallel Boards for the hospital and faculty of medicine with identical membership
- Hudinger Hospital Stockholm has Karalinska University members on its board and its operation and management are integrated to maximise effectiveness
- Inspital Berne - the hospital, which is Foundation owned, and the University of Berne Medical School have an operating committee and shared executive to Manage their academic activities

**Coalition**

- Kantospital Basle. The Hospital Owned by the Canton of Basle has, with the University of Basle, a jointly appointed research director with budgetary and recruitment authority to the respective institutions for the combined resources of the Hospital and University
- Royal Marsden/ICR. The Royal Marsden has created an effective coalition through cross appointments and joint strategy/operating committees with its neighbouring Research Institute

**Community Networks**

- Karalinska Hospital Stockholm has a loose affiliation with Karalinska University, but as a county council governed institution, no direct University participation in its governance. This, hospital believes, has lead to deterioration in its academic standing
- Network North Toronto consists of a geographic cluster of hospitals, university and community, who co-ordinate clinical, teaching and research initiatives through a board to which they all appoint members
- Partners HealthCare, Massachusetts. In March 1994, the MGH joined with Brigham and Women's Hospital to form Partners HealthCare System, Inc., an affiliation established to create an integrated health care delivery system providing excellent, cost-effective care while maintaining the hospital's historic dedication to teaching and research. These hospitals are the site of the Harvard Medical School. All clinical and scientific staff are full Faculty members.