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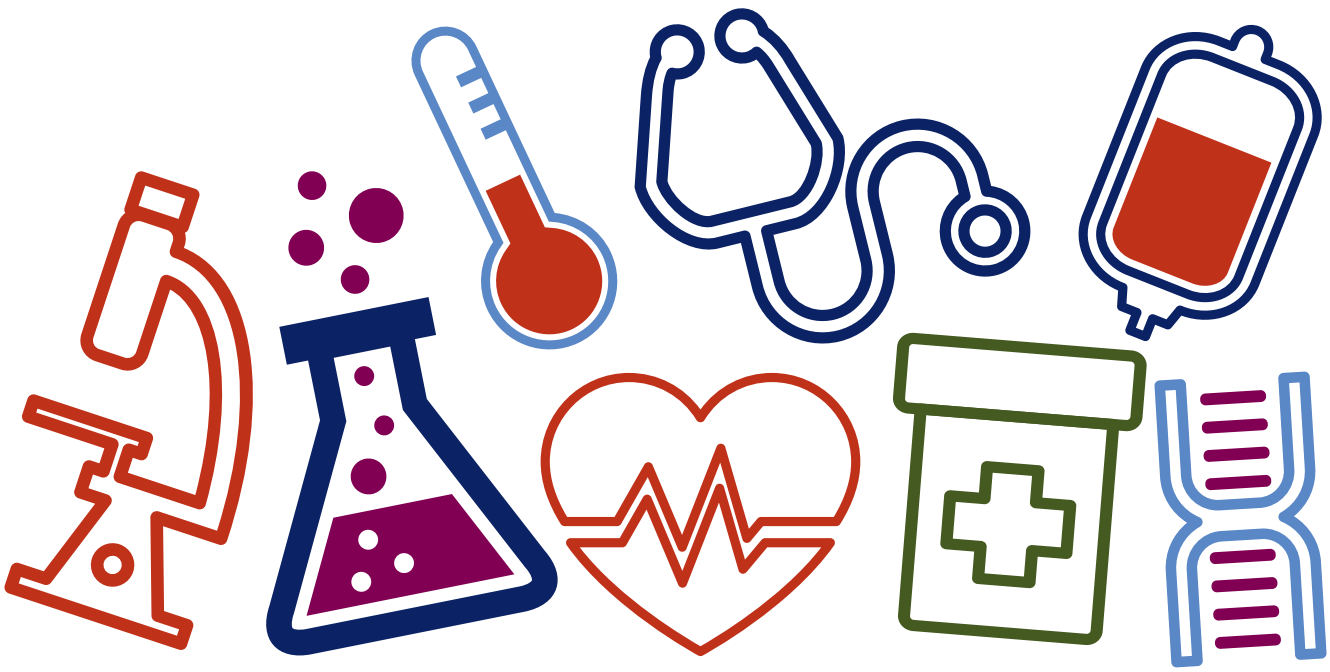
Grant Thornton

A Healthy Relationship:
how can organisations effectively partner with the NHS?



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Introduction

It is now 20 years since the first Private Finance Initiative (PFI) hospital was announced and almost 15 years since the market based reform of the NHS paved the way for greater independent sector involvement in the delivery of NHS services. Partnerships between independent sector providers and the NHS are now relatively common and more are expected to emerge as the NHS progresses with the Five Year Forward View.

Key stakeholders from across the independent sector and the NHS gathered at a round table jointly hosted by Grant Thornton and Trowers & Hamlins to discuss what makes effective partnerships and how they are developing to meet the changing needs of the NHS.

Chair Rhiannon Williams, Healthcare Advisory Services at Grant Thornton, began by charting a brief history of public private partnerships in the health service.

"I think it started with PFI and Local Improvement Finance Trusts (LIFT), which was really a financing arrangement about infrastructure," she said. "At the time, we did flirt with the idea of bringing in pathology and clinical services but it was all too difficult so, for me, the real ground-breaker was the independent sector treatment centre programme (ISTC) in 2003. That was a proactive drive by the government to encourage the private sector to come in and provide services for the NHS and that's been followed by Any Willing Provider and Any Qualified Provider. On the commissioning side, we've also had Framework for procuring External Support for Commissioners (FESC), which brought across the likes of Humana, McKesson, United and Aetna."

There are numerous examples where the NHS and independent sector have worked together, but how have those relationships developed over the last 20 years, what makes an effective partnership and are there still barriers to overcome?

> "What we are seeing in practice, and our roundtable participants have evidenced this, is that there are really positive examples of good partnering arrangements at a relatively local level. The future is not going to see partnerships with the NHS on a nationwide level, but locally led solutions, based on the needs of the local population that can then be replicated in other local areas where the needs profile is similar."
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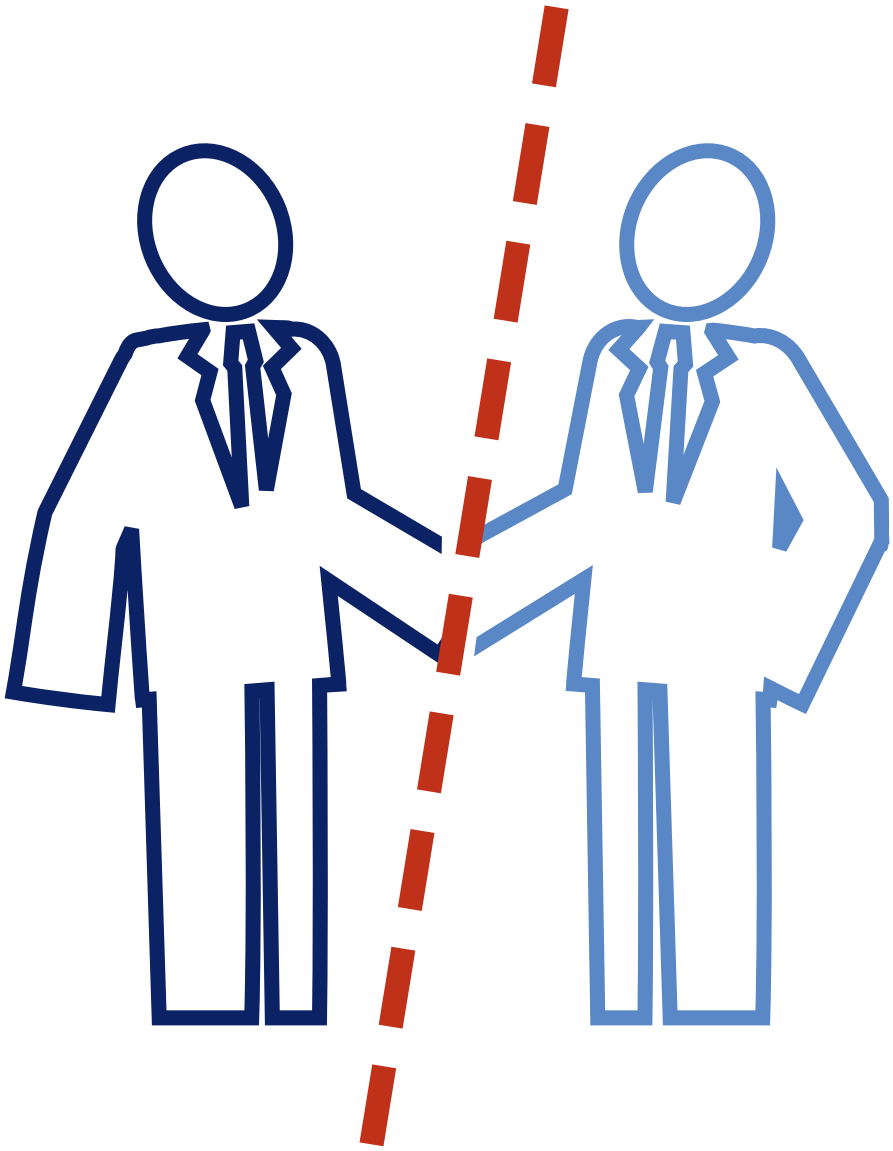
> Alison Chivers - Partner, Trowers & Hamlins



Long-Term Relationship or One-Night-Stand?

Historically, the NHS has long turned to the independent sector when it has needed additional capacity, whether for elective surgery, diagnostics or support services. Policy direction over the last two decades has broadly been aimed at moving those relationships away from short-term capacity overflow agreements to longer term arrangements. However, the panellists agreed that although they exist, examples of genuine strategic partnerships between private providers and the NHS remain few and far between.

The bulk of diagnostic services provider InHealth's activity is NHS funded. However, Chief Executive Richard Bradford said that only around a third of the company's NHS contracts felt like genuine strategic partnerships.

"With the other two thirds," he said, "we feel much more like a supplier of a bit of capacity which, if all things were equal, could just be turned off."

HCA has a very different type of relationship with its NHS partners as only a small percentage of its patients are NHS-funded. HCA operates four partnerships with NHS Trusts to provide privately funded pathways in private patient facilities within the NHS. The partner NHS organisation benefits from a new revenue stream that it would struggle to replicate on its own. However, its head of business development for NHS partnerships Sam Lock said there was similar variability in the nature of its partnerships with NHS Trusts – with some having more transactional characteristics than others.

A key reason for this, he said, was the different commercial structures behind each arrangement.

"Rent and revenue share modes, for example, provide the partner NHS Trust with a reasonably consistent level of income. Equity joint ventures, on the other hand, allow for the Trust's income opportunity to be proportionately aligned to the success of the partnership," he explained.

According to Michael Steel, Chief Executive of Greenbrook Healthcare, much of the problem lies in the fact that contractual arrangements are often quite short-term in their structure, particularly in the urgent care sector.

"We tend to operate on 3+1+1 contracts so we know we don't have long before we have to re-bid. I wouldn't necessarily say that's structured for the long term. I think the partnerships we have with NHS Trusts where we bid jointly to commissioners to deliver urgent care centre services are probably better and probably longer term," he said.

Private hospitals operating outside of London have become increasingly reliant on NHS work over the last decade. LaingBuisson estimates that combined NHS revenues from the top five national private healthcare groups - General Healthcare Group, Spire Healthcare, Nuffield Health, Ramsay Health Care and Circle – has more than trebled since 2008 and reached over £1 billion in 2015, the latest year for which figures are available. However, in recent years the main driver has been e-referral (formerly known as Choose and Book) rather than contracts with commissioners.

One Healthcare Chief Executive Adrian Stevensen said it remained challenging to build long term relationships with NHS commissioners as "spot" and other contracts were typically for months rather than a year or more. As a relatively new market entrant, the company, which provides surgical and diagnostic care based on the US and Australian ambulatory care model, has consciously focused on developing positive relationships with GPs, who have more invested in ensuring patients are treated as quickly and efficiently as possible.

"We tend to concentrate at GP level because it's non-threatening, it's practical and it enables the patient to access a private hospital at a tariff rate so it's very simple, the GPs are the gateway to the system and for us that works." he said.

As well as a short-term approach, the way independent sector providers are viewed by parts of the NHS has also proved challenging to the development of longer term partnerships. In spite of an increasing role for the sector in the delivery of NHS services, many members of the panel felt non-NHS providers were still viewed as sitting outside the system rather than part of it.

Antonia Dalton said GenesisCare had come to the UK with the idea that it would be able to replicate its success in Australia, where private provision is "totally integrated" into the public health service.

"In Australia, we have many outsourcing arrangements where we provide radiotherapy services on behalf of the public sector in hospitals and tertiary hospital settings, completely transparent and integrated into the hospital so the patient actually does not realise the services are being provided by a private provider. They are in a public hospital but we provide the services. We came to the UK two years ago thinking there was an opportunity to do the same, that the UK was similar to what Australia looked like 15 years ago in terms of public private partnership in healthcare but we have had limited success to date. We do have NHS contracts in the UK but they are for overflow into our private centres," she said.

Richard Bradford asked if it was worth reflecting on the word "outsourced"? He said there was a massive difference between providing overflow support and being a true strategic partner that supports the NHS "brand".

There are times when we as the independent sector providers are a dirty little secret and provide the capacity overflow rather than being able to engage on a strategic partnership basis over the long term, he said. "Certainly, the use of the term outsourcing partner is not one that's commonly accepted across all parts of the NHS."

"We need to restore trust between the NHS and the private sector"

Rhiannon Williams – Healthcare Advisory Services, Grant Thornton

The Barriers to Successful Partnership

So, why is it that, almost 15 years after the announcement of the ISTC programme, there are still so few examples of genuine partnership working between the independent sector and the NHS?

Ironically, some of the panel felt it was the very reforms designed to bring the independent sector into the NHS which have stood in the way of true partnership.

According to Tim Briggs, Director of Strategy and External Affairs at NHS Improvement, many of the challenges being faced today can be traced back to the centrally-driven ISTC programme, which in some cases, was forced on unwilling local health economies.

"Going back to 2003 when ISTCs came along the NHS was flush with cash and the only driver was waiting times. There was absolutely no quality metrics in that whatsoever and we all know that while some ISTCs worked well, others didn't. Some of the revision rates were very high, such that the revisions required from some ISTCs were more than the original contract, so that did not work well," he said.

The hostility towards the independent sector arising from those early ISTC contracts has been hard to shift, and the perception that, in electives at least, the independent sector cherry picks the simplest and most profitable cases remains pervasive.

"In the NHS, we need sites to do both routine and complex work and some of the complex work is not reimbursed at a tariff that makes it affordable. Therefore, if you lose the simple stuff you are going to go bust but in the wider private sector at the moment they do not do the complex work and why would they?" said Tim Briggs. "If you lose that huge tranche of elective work then you're losing charge of the income that makes you money."

Medical Director at UCLH Charles House agreed that this imbalance had created friction in the relationship between the NHS and independent sector.

"It is sometimes perceived that the public sector is picking up a lot of the risk. It very probably doesn't feel that way to the private providers but the NHS is as we all know a great national treasure and those are tricky messages to get around in the first place," he told the panel.

Developing partnerships with the NHS is a complex business. To be successful, they have to strike a fine balance between commercial viability for the independent sector partner and value for money for the NHS. And, when they involve treating NHS patients, they have to be designed in a way that provides capacity without undermining NHS finances.

However, some panellists thought independent sector providers were unfairly blamed when things went wrong and that commissioners should take greater responsibility for contracts with adverse consequences.

"I think it's really unhelpful to talk about cherry picking," said Michael Steel. "The NHS doesn't just provide services, it commissions services so I know that our organisation can't just pitch up and say we're here and we'd like to provide services. We have to be commissioned and it's NHS commissioners that decide the terms of our contract, what we can and can't do and how we operate. We work to very detailed specifications and if there is a provider within the independent sector providing the wrong type of services or not the most difficult services, then the NHS needs to commission those services more rigorously in my opinion."

The structure of an NHS tariff system which essentially rewards those providers that undertake more of the simple work and less of the complex or unplanned activity has also impacted on the NHS/independent sector relationship.

"The problem the NHS has is it doesn't have enough money and the tariff structure is sometimes a hindrance," added Michael Steel. "A lot of the problems the NHS has when it works alongside independent sector providers is because the tariff system is not flexible enough to help them to commission as they would want to do. It can't be possible that an NHS provider is best every time and the independent sector is not. The NHS needs the freedom to work much more flexibly than it does."

Other panellists felt that relationships between the independent sector and NHS were most tricky when they involved large-scale change, particularly if it involves the transfer of whole patient pathways.

Antonia Dalton said culture change was difficult, though not impossible, to overcome.

"When you start talking about treating NHS patients, you get into a whole raft of perception issues regarding how to manage, define and report quality and what private involvement means for staff. These issues are all manageable, but there is a cultural leap to be made in the UK. NHS providers and private participants who do this well stand to benefit," she said.

Speaking from an investor perspective, Sam Gray, Partner at Apposite Capital, said schemes that involve whole-scale shifts in the way the NHS works can be off-putting for financial backers.

"With my investor hat on, one of the questions we ask when it comes to investment cases is does it require the NHS to do anything different in the next five years to what it currently does. If the answer is yes, we would have to take a very long, hard look at it. If it's a transactional thing, such as moving a laboratory from an internal one in the basement, then it's not radically different but if it's a transformation of how people work and combinations of how people work together, that's different. It can work in an isolated incident but to make it work repeatedly, to build a business around it, can be quite tough," he said.

"Simon Stevens has said that the three main areas the NHS needs to address to deliver on the 5 Year Forward View are workforce, estates and IT. We should be learning from how private sector healthcare businesses operate."

Hilary Blackwell - Partner, Trowers & Hamlins

Roundtable

List of participants

Grant Thornton	Rhiannon Williams (Chair) - Healthcare Advisory Services
Trowers & Hamlins	Hilary Blackwell - Partner
InHealth	Richard Bradford - Chief Executive
NHS Improvement	Tim Briggs - Director of Strategy and External Affairs
Trowers & Hamlins	Alison Chivers - Partner
Renal Services	Stefano Ciampolini - Chief Executive
GenesisCare	Antonia Dalton - International Business Development
Apposite Capital	Sam Gray - Partner
UCLH	Charles House - Medical Director
Grant Thornton	Peter Jennings - Director Corporate Finance
HCA Healthcare UK	Sam Lock - Head of Business Development
Viapath	Jennifer Nel - Commercial Finance Director
Livingbridge	Sanjay Panchal - Associate Director
Greenbrook Healthcare	Michael Steel - Chief Executive
One Healthcare	Adrian Stevensen - Chief Executive

> “It is apparent from both sides that there is an enthusiasm and a commitment to partnering and working together. What became clear during the roundtable is that perhaps existing commissioning structures (short-term outsourcing arrangements) are not delivering what either party needs – they are not protecting the financial future of the NHS, nor are they encouraging the capital investment that the private providers might otherwise bring to the partnership. We are certainly going to see new models developing that will address this and enable strong, lasting, partnerships to be forged.”
>
> Alison Chivers - Partner, Trowers & Hamlins



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People buy people and the key to successful partnering is long term relationships built on well-earned mutual trust and respect.”

Hilary Blackwell - Partner, Trowers & Hamlins





The Makings of Successful Partnerships

Despite the inherent difficulties, partnerships between the NHS and independent sector can and do work. And in recent years, a growing number of long term relationships have developed to deliver NHS services across multiple specialties. So, what are the key ingredients for success?

The consensus among panel members was that partnerships worked best when they involved NHS and independent sector providers coming together under Joint Venture-type arrangements or as part of consortia to bid for NHS contracts.

Michael Steel said: "Every contract (in urgent care) that we've won has been through a public competitive tender. We often partner with NHS provider organisations to bid together for these services. The best provider wins, best value is almost always achieved and commissioners now have a good understanding of how to contract for urgent care services. Together with our NHS providers, we deliver a higher number of patients through the system faster and at a lower cost than a traditional A&E would because we are really specialised in what we do. These types of partnerships are what the NHS needs and we shouldn't be thinking about this as a threat to the NHS, we should be thinking about how we can make the NHS stronger. Independent providers need to be commissioned by the NHS, but there shouldn't be any reason why specialist independent sector providers shouldn't work alongside NHS providers to deliver selected services where they can deliver clear benefits."

Jennifer Nel, Commercial Finance Director at Viapath, the pathology joint venture between Serco, Guy's and St Thomas' Hospital Trust and King's College Hospital, agreed that partnerships work best when all members are aligned to a common goal.

"It's quite difficult when you've got two teaching hospitals that historically have been competitors and Serco, who are sometimes seen as the private sector but where it's worked well is when they've had a shared vision and can move forward change. Even moving a lab can be quite challenging but it works well when there is commitment from all parties to make change happen," she said.

Chair Rhiannon Williams added that in her experience, having the NHS as a partner in the provision of services made Joint Ventures more acceptable to commissioners and other NHS organisations than purely private organisations.

Referring to her time as managing director of Radiology Reporting Online, a Joint Venture between UCLH and an Australian teleradiology company, she said: "There is no doubt that having the NHS brand as a 50% owner was a huge help going around the country."

Success can also hinge on the type of service being provided. Historically, the NHS has been far more receptive to independent provision of support and ancillary services, particularly when it lacks its own capacity, than it has to non-NHS providers taking over whole swathes of direct patient care. And the panel felt that the provision of discrete services, such as pathology and radiology, was open to less criticism than electives or primary care.

"There is no doubt about it, I think what makes teleradiology really suitable for this is there is a huge shortage of radiologists around the country, that there is overwhelming need for the service and there's a huge increase in the number of diagnostic images being required year on year," Rhiannon Williams continued. "It is growing and the current service can't keep up with it."

Tim Briggs indicated there could be "big wins" for the independent sector in pathology and radiology driven by the Carter Report and the mounting pressure on NHS finances.

"Pathology is being reorganised at the moment," he said. "Carter produced his report in 2006 and nothing happened, now it is going to happen and why it is going to happen is that there is no more money."

Dialysis is another area where the NHS lacks both the capacity to meet both growing demand and to invest in new equipment. Since it is seen as supporting rather than taking over patient care, Stefano Ciampolini, Chief Executive and Co-Founder of Renal Services, believes it is less controversial for the NHS to let go.

"I think that the private sector, which now has decades of experience in delivering dialysis more as a business process than a treatment can bring efficiencies and that's why more and more dialysis is being outsourced in this country. When I started my company, it was probably about 10% that was delivered by the private sector and 90% by the NHS and now it's more than 30% private and the rest NHS so I think we have decades of data to show that the private sector can do a good job at this," he said.

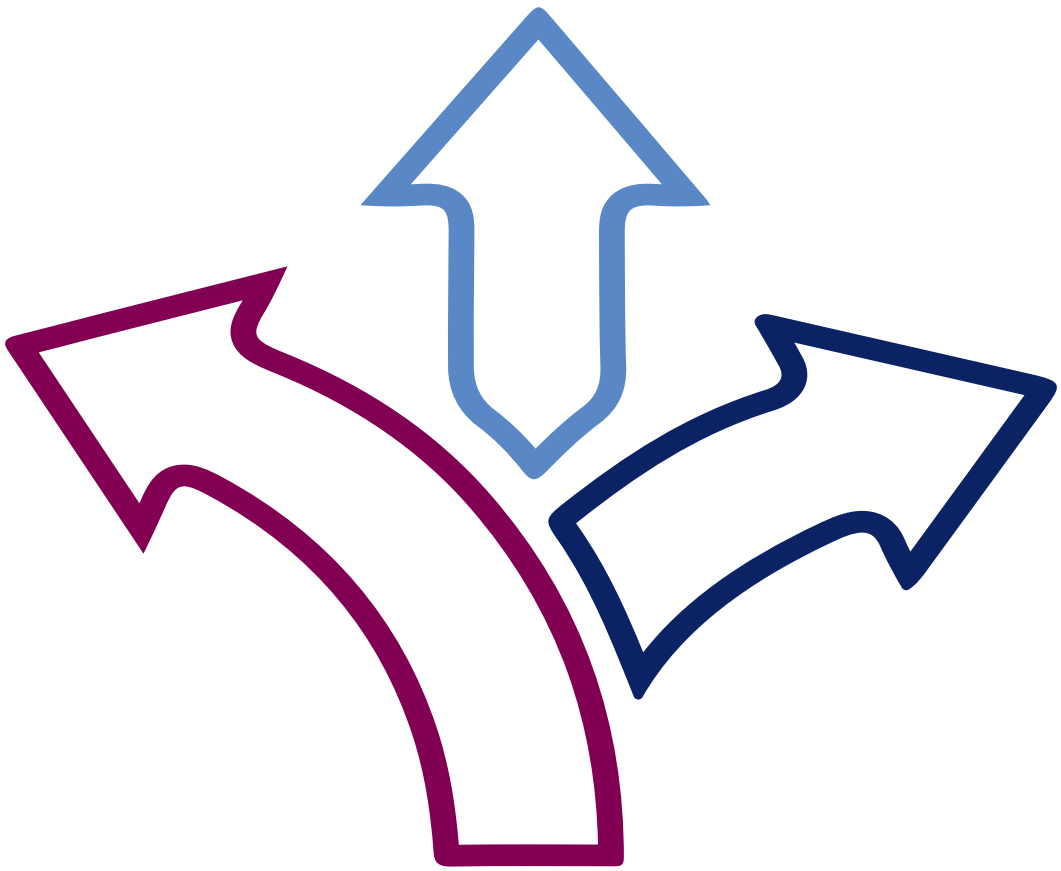
According to Charles House, one of the reasons support service partnerships work well is because they do not necessarily involve the transfer of NHS clinical staff. "The pathology joint venture that we're in is interesting because it effectively outsources the laboratory service but keeps the consultant staff as part of the trust," he said.

However, he added that it was crucial for services delivered by joint venture partnerships to become embedded and in a system as large and complex as an NHS Trust, that takes time.

"It's a gradual process," he said. "we started on our journey about eight years ago when we first started outsourcing our open heart CT reporting, and then in more detail from about six years ago when we started using our partnership and our Joint Venture radiology and reporting online to provide some of our routine reporting as well. It's a slow process but we now have a position where reporting of the majority of plain films and a significant proportion of our CT and our MRI is an embedded, resilient relationship. And that, I think is what's critical."

Antonia Dalton thought transparency was another essential element of a successful partnership.

"In our successful tenders in Australia, we have built a financial and operating model and shared it with the Health Service (equivalent of NHS Trust) so they can see exactly what our returns are, what we are spending, what we are committing to over the life of the contract and how much money we make, how many staff are involved, the level of proficiency of those staff, and what equipment we are providing. They know from day one before they enter into any long-term arrangement what it is we will be providing and committed to," she said.



Opportunities on the Horizon

The NHS is currently in the midst of a major transformation; the creation of Sustainability and Transformation Partnerships (STPs), Accountable Care Systems (ACSs) and Accountable Care Organisations (ACOs) is set to radically change the way services are commissioned, funded and delivered.

It is still not clear precisely what form these new structures will take or how they will deliver the New Models of Care being piloted in the Vanguard sites. There has been little explicit mention of independent sector provision in the policy documents but they do allude to a greater emphasis on partnerships which bring together all stakeholders in the local health economy. And this could lead to a greater role for the independent sector.

Hilary Blackwell, a Partner at Trowers & Hamlins said her team had been talking to a number of ACOs about how things might be different in future. "One thing they've said, particularly if they are acute hospital led is that they do think there is a role for private sector partners and they are very much in this partnering mode because they realise that if they take the whole population budget they need everyone in the system brought in," she said.

In recent years, government policy has moved further away from the idea of competition in the NHS to focus on collaboration. Tim Briggs believes this is a theme that will take centre stage as the NHS moves further along the journey of "doing more for less."

"We are trying to work with all the stakeholders and I'm sure there will be opportunities for partnerships with the private sector but we have got to work much more in a collaborative way than we have done before because there is no more money," he said. "I've been in the NHS for over 36 years, and I want to see better care for patients so, yes, working with industry is good when its collaborative rather than competitive."

Michael Steel thought there would need to be more flexible commissioning of services to make collaboration a reality. "Competition between providers isn't necessarily good but partnership working is very good and we need to improve upon that," he added.

According to Richard Bradford, there also needs to be more emphasis on what independent sector providers can do to "support the NHS brand".

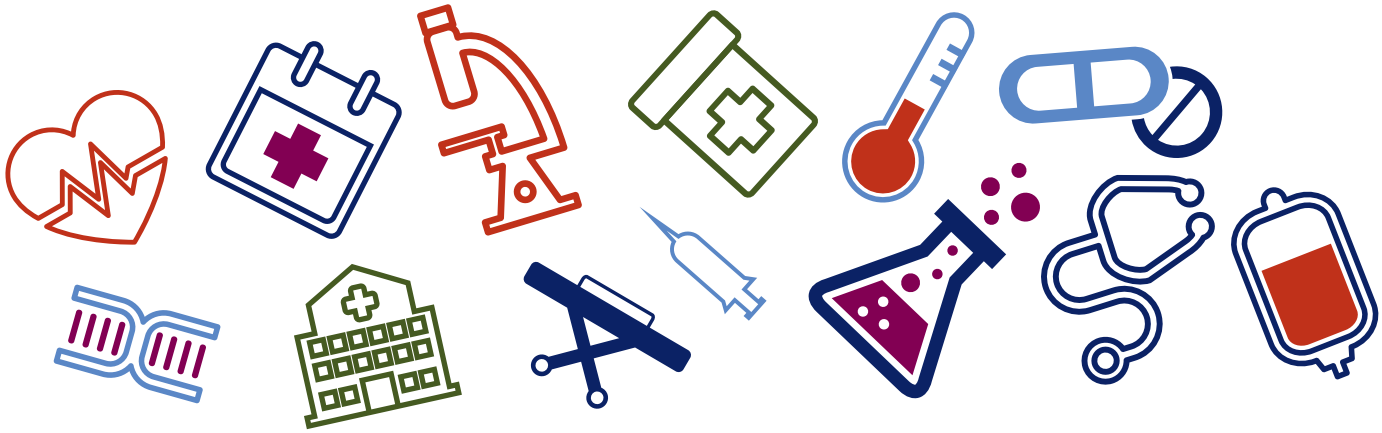
"I think the world is very different now," he said "I believe in the NHS and you can support that brand provided you are aware of the service definition you are trying to support and that doesn't have to be competitive. There is a legislative framework and as long as there is a best value or a benchmark test on who the best provider for each of those services is, and there is an openness to partnership, that is a good place for the independent sector to be working - with a great brand and trying to support that brand. The only thing I would say is that one should not assume every independent sector provider is the same in terms of quality just as you can't assume that every part of the NHS is the same in terms of quality."

It is this latter point around quality that Tim Briggs believes will drive commissioning, and the nature of partnership working, in the future.

"What we are going to do is by 2018 we'll have hard data based on outcomes, quality, infection rates and readmission rates for 33 specialties available from our data warehouse. And if you said to me what will drive the STPs and ACOs, it will be that data because it will be the first time they will have access to it for every trust. We can see who is doing what and what the quality outcomes are like and that will drive the agenda very quickly," he said.

Tim Briggs is the architect behind the Getting IT Right First Time (GIRFT) programme, which is led by frontline clinicians and aims to improve the quality of medical and clinical care within the NHS by reducing unwarranted variation in service and practice. Started as a pilot within orthopaedic surgery, its methodology and processes have now been rolled out to 33 specialities and a formal GIRFT implementation infrastructure is being developed.

"So, the quality agenda is how we are going to drive [change]," Tim Briggs told the panel. "Plus, the NHS is going to have to work in a different way and I've called it the reverse acute provider model where we are going to have to ring-fence the elective activity that's going to have to pay the bills and then we're going to build the acute services around as each of the GIRFT specialties produces their report. Now there is a role for partnership working across the NHS and private sector but I think the relationship is going to have to be different. The relationship has to be a partnership. Trusts at the moment are losing a lot of income and are left with the emergency work and we're all going broke and if we want an NHS that's going to survive then that elective work, which pays the bills, is going to have to be done within the NHS provider system but probably in partnership with different provider sector people - but with a different relationship to where it is now."



Case Studies

InHealth – Evolution of community-based model of care

For seven years, InHealth have successfully delivered diagnostic services under the London Diagnostics Service contract. Over a million tests were delivered by InHealth over this period and they built excellent relationships with Acute Trusts and CCGs alike. The strength of these relationships was demonstrated when virtually every service was transitioned from the large scale LDS contract to individual contracts between InHealth and the CCGs, via procurement, working with local GPs, with no disruption to service.

The close relationship with the London GPs and Commissioners allowed InHealth to assess demand and propose solutions, increasing efficiencies and saving costs across the region, focusing their efforts on increasing access to diagnostic services in community settings.

Since then, InHealth has invested in stand-alone Diagnostic Centres in high street locations including Waterloo, Hornchurch, Ealing, Golders Green, Shepherds Bush, Milton Keynes and Stratford. Many of these are built from scratch, with some such as Waterloo and Stratford being subsequently expanded to accommodate additional MRI scanners.

These centres now provide a range of diagnostic services, including MRI, reducing waiting times, expediting the patient pathway, leading to substantial cost savings for CCGs and reducing capacity pressure on Acutes. This has also reduced the average time from first GP visit, through the diagnostic testing, reporting and referral to onward care to under 11 days. Now open seven days a week, from 8am until 8pm, our diagnostic centres are fully booked on a daily basis.

The Patient Referral Centre (PRC) has been a key factor in the success of our community-based delivery model. Staff at the PRC handle in excess of 500,000 telephone calls each year. With medical triage facilities and constantly evolving technology to optimise our booking service, our trained staff can ensure that patients receive the best possible service and care, from the moment that they are referred. The flexibility that InHealth can now offer as a result of their community focused delivery models and increased capacity allows them to offer the most convenient appointment to the patient, closest to their home or work address and across CCG borders. This flexibility maximises efficiency, reduces waiting times and reduces costs by eliminating unallocated appointments.

Healthcare at Home – Virtual ward schemes to improve patient flow

Ensuring that patients can be treated in their own home where appropriate has significant benefits not only for patients and their families but also helps free up capacity within NHS trusts, allowing them to focus on developing patient services rather than constantly 'fire-fighting' due to a lack of beds.

Healthcare at Home works with 13 NHS trusts to provide a supported discharge service which aids patient flow throughout hospitals and allows patients to receive complex clinical care in their home via "virtual wards", rather than as in-patients in a hospital.

Healthcare at Home's expertise lies in providing care for people with cancer, the frail elderly as well as re-ablement, pre- and post-operative surgery and inflammatory disease services. Appropriate NHS patients are identified and then the referring clinical team works with the homecare team and the patient to agree on a fully personalised care plan. While in their own home the patient is closely monitored by a clinical team and a home care team through a 24/7 telephone based care bureau which has access to electronic patient records, with the patient remaining under the clinical responsibility of the hospital consultant or GP.

Lewisham and Greenwich NHS Trust has been working with Healthcare at Home for just over two years. Patients who need sub-acute care, for example an IV drip or a regime of antibiotics, can recover in their own home under the care of Healthcare at Home nurses. Consultants from the trust continue to oversee the care and are responsible for discharge, but the model of care helps to increase bed capacity and enables greater patient flow. Staff work alongside clinicians within the hospital to identify appropriate patients for the service.

Patient flow had initially been a challenge at the hospital with large numbers unable to leave the emergency department and in 2015, trust leaders agreed with commissioners that a different way of working was required to bring about improvement. Lee McPhail, Director of Service Delivery for the trust says: "We took time to set up the service. Our relationship with Healthcare at Home has evolved over time; they know what we want and we can establish a more bespoke service when we need one. For it to be successful it was vital to engage the trust and support of the clinicians, some of whom had had a negative experience with different models of care in the past."

In working with NHS trusts, Healthcare at Home has created 379 virtual beds, the equivalent to a small district general hospital. Data from 2016 showed that all participating trusts saved £490 per inpatient spell and that the NHS could save half a million inpatient stays a year if the virtual ward scheme was introduced across all its organisations, saving at least £120 million.

Final Word

Despite the challenges, partnerships between the NHS and independent sector can not only be successful but are, in many cases, essential. Increasingly, local health economies are struggling to provide all the services required by patients within their limited financial envelopes. Along with the New Models of Care designed to save money through increased efficiency, this will present new opportunities for independent sector providers. However, the panel agreed that it will also require new ways of working which are based on collaboration rather than competition with long term views taken by all parties sharing common goals, with the private sector being viewed as part of and not outside the healthcare system.

Peter Jennings, Director of Corporate Finance at Grant Thornton, outlined some of the attributes that facilitate successful partnerships as detailed in figure 1. He commented that there was "a real opportunity to learn from past experience and to build more positive and long term partnerships going forward" but was keen to point out that we need to be "mindful that there are some real barriers that can make relationships both difficult to implement and to sustain."

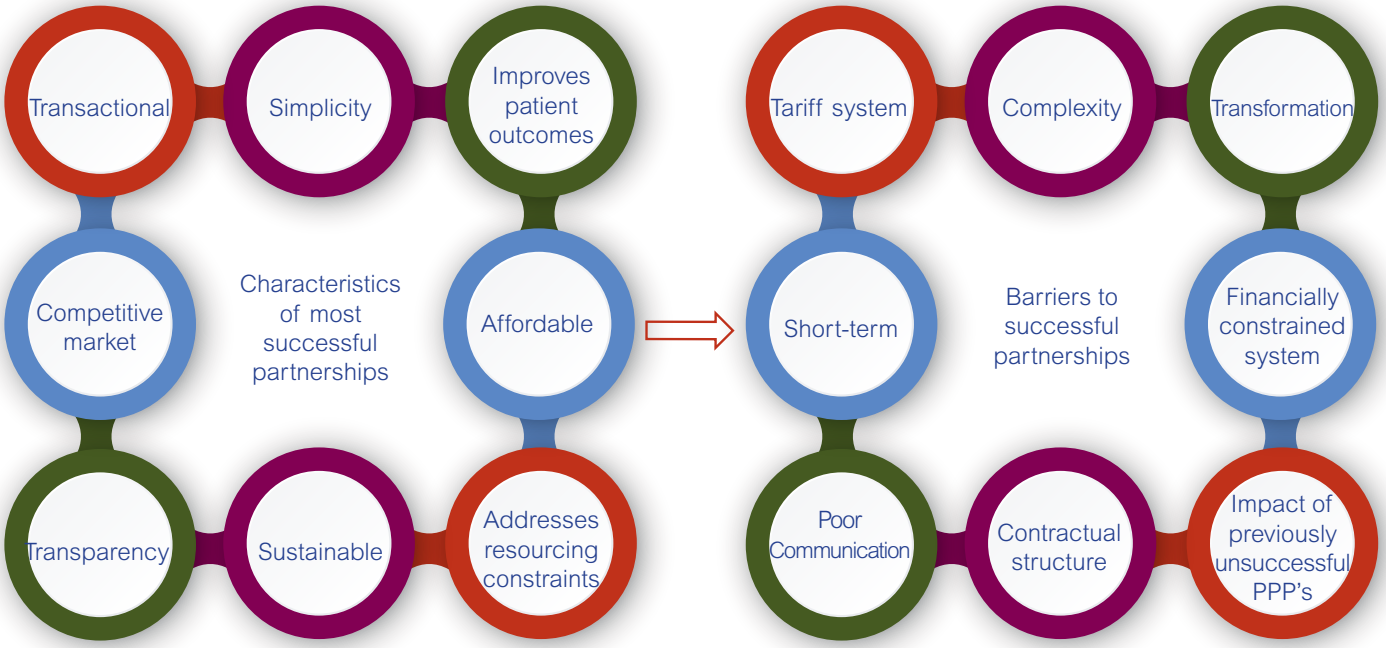


Figure 1

Chair Rhiannon Williams summed up: "We know we're operating in a world of limited money. Every conversation I have, whether it's with Department of Health or NHS England ends with there is no more money in the foreseeable future. I think the upside, and what to take from this, it's possible to make considerable improvements, but if the NHS is going to work with the private sector, the relationship has got to move away from being confrontational and partnerships should become more strategic. This requires both sides to commit time to these arrangements and ideally, the contract should be locally led in the NHS."

> "An open-book approach is required so there is a common understanding of cost of the contract and returns to the private sector"
>
> Peter Jennings - Director Corporate Finance, Grant Thornton

Further information

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