Governance and Institutional Appraisal (Draft 2)

This section will address the questions: a) is the programme feasible in the institutional context and b) does it help build capacity? –how?[1]

Part 1: Feasibility in the Institutional Context

1. Institutional Context

Figure 1 of the Social Appraisal provides an overview of range of institutional partners that may be involved in the HPS.

The HPS aims to make significant developmental contributions through a strand of activity dedicated to paired institutional partnerships and direct capacity support from one institution to another. There is a long history and wide experience of paired institutional partnerships and "twinning" arrangements both in the UK and elsewhere.[2] It is clear that such arrangements provide rich opportunities for exchange programmes, secondments and mutually beneficial capacity strengthening.[3] Arrangements can last for several years and offer the potential for a supportive institutional environment for IHP. This has benefits for participating staff from each country, and can help facilitate larger more integrated initiatives. Paired institutional partnerships may also provide opportunities for a broader range of skills exchange, for example, relating to healthcare management, administration and systems development, and more specialised service delivery areas. Experience has shown, however, that paired institutional partnerships do tend to favour urban centres and tertiary institutions. The HPS, therefore, aims to ensure the benefits of paired institutional partnerships are extended to primary health care facilities and rural areas; this provision will be addressed through the procurement process.

Case study: Institutional partnerships with Somaliland
In 2000, two doctors based at Kings College Hospital secured a grant to take an assessment visit to Somaliland. Ten years on this visit has led to a series of partnerships between King's Health Partners Academic Health Sciences Centre and a number of healthcare institutions in Somaliland. By 2006, the link was supporting work with two medical schools, four nursing schools, the medical and nursing / midwifery professional associations, and three hospitals. A programme of work was developed to strengthen the capacity of training institutions such as nursing and medical schools. Work has also been done to support the professional associations with standards and accreditation. There have also been specific strands of work in areas such as mental health, midwifery and laboratory and pathology skills training for technicians. The medical education programme led to the 2007 graduation of the first locally trained doctors in the history of Somaliland - a landmark moment for the health sector.[4]

It is important that this programme adds value or complements existing initiatives and does not duplicate the role of an existing structure or organisation.

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[1] DFID. 2005. *Essential Guide to Rules and Tools: The Blue Book.* Section B5:2. London:DFID

[2] See James J, Minett C and Ollier L. 2008. *Evaluation of links between North and South Healthcare Organisations.* London: DFID Health Resource Centre for an extensive description and analysis of paired institutional arrangements.

[3] Department of Health. 2010. *Framework for NHS Involvement in International Development*. http://www.ihlc.org.uk/news/framework.htm

[4] Source: Department of Health 2010:23. Op.cit.

Table 1 provides an overview of the roles of some key UK structures and organisations that are likely to be involved in the development of international health partnerships.[5]

Table 1: Overview of Some Key Role-Players

Structure	Role
Strategic Health Authority International Health Group (supported by NHS and DFID)	• Raising awareness in the NHS, other sectors and developing countries about the role of NHS involvement. • Promoting effective NHS involvement in international development through: assessment of best practice; ensuring alignment of NHS efforts; guidance on preparation of NHS staff; promoting good governance, risk management and cost-effectiveness of international health links.
NHS Global (new organisation - launched March 2009)	• Identifies and develops commercial opportunities for the NHS; • Brokers partnerships between NHS organisations and overseas clients. - Intends to work closely with the International Links Centre, the Fund and the Strategic Health Authority International Group to promote best practice and strategic co-ordination. • Identifies potential legal issues and risks and provides advice on Intellectual Property management; • Supports NHS marketing and communications.
UK-based NGOs (e.g. VSO, Oxfam, Save the Children, Care, Concern, Merlin, Red Cross, Skillshare)	• Support placement of NHS staff • Ensure individuals are part of organised development projects. • Assist with practical and logistical issues, training, orientation, monitoring, evaluation. • Support documentation of best practice, lesson learning, awareness raising. • Provide technical and management support and expertise in accountability and advocacy and community development approaches.
UK universities – especially Health Innovation and Education Clusters (HIEC) (partnerships between NHS organisations, the higher education sector, industry and other public and private sector organisations).	• Support high quality patient care and services by quickly bringing the benefits of research and innovation directly to patients • Strengthening the co-ordination and relevance of education and training.
Professional Associations (such as Royal Colleges)	• Support education, training; address issues of accreditation and professional support. • The International Forum of the Academy of Medical Royal Colleges is an independent body that brings together the representatives of the international departments of medical, nursing, midwifery and other health professionals' royal colleges and associations. The Forum aims to coordinate international activities of the colleges and faculties.
Trade Unions	• Building relations between workforces and as a means of exchanging best practice and sharing relevant experiences. • Mobilisation of international connections to support projects and policy work undertaken by the NHS and ensure that trade union partners in developing countries 'buy into' projects. • Supporting the development of sister unions in developing countries helping them to play a full and positive role in the development of local health services.

[5] Source: Department of Health. 2010. Op. cit.

It is important that the new HPS builds on the existing programme. It has been agreed that the Links Funding Scheme will continue to the end of the present contact before being subsumed into the larger funding scheme. The contract for the Links Centre will be cancelled, with the Centre being replaced by the *Healthbay*. Functioning and continuity of the HPS will depend on the management of smooth transitions through this process, as well as development of clear communication strategies for key stakeholders.

2. Implications of international health partnerships for the NHS

There has been extensive work done on reviewing the implications of global health partnerships for the NHS, and in developing guidelines and resource materials to support NHS structures, organisations and staff. Documents such as the *Framework for NHS Involvement in International Development* (2010), the THET *International Health Links Manual* (2009, Edition 2) and the Department of Health's *International Objectives and Ways of Working* (2009) provide comprehensive guidance on managing participating staff, financing and ensuring cost-effectiveness. The HPS also makes provision for the management agent to work with the NHS and relevant professional associations to ensure pension rights of longer-term volunteers are protected and, where possible, there is accreditation for international experience.

Documented best practice on governance and risk management of IHP is summarised below:

Summary of Best Practice on Governance and Risk Management

Review of reports and evaluations suggests that NHS Trust Boards and governing bodies overseeing international health partnerships (IHP) should ensure that:

- The aims and objective of the IHP are known and that those responsible for taking forward the partnership work are also known and held to account (this should generally be articulated in a formal proposal or business plan).
- The strategy for the IHP reflects and complements organisational and wider NHS policy on global health.
- Appropriate risk assessments and risk management planning is undertaken (as part of due diligence and duty of care responsibilities).
- Roles and responsibilities of all parties to the IHP are formalised within a memorandum of understanding or partnership agreement, and key activity areas incorporated into relevant annual workplans.
- IHP activity is planned, monitored and evaluated in order to ensure the IHP is of high quality and able to have maximum impact.
- There is transparency over sources of funding, and how that funding is disbursed to support IHP activity.
- Staff time spent on IHP activity is transparent.
- Regular reports (at least annually) are made to the NHS Trust board and Charities Commission if appropriate, thus enabling IHP activity to stand up to public scrutiny.

It is recommended that the above themes are considered in the procurement process for the HPS.

3. Feasibility of the Approach

Recent Department of Health publications (such as the 2009 International Objectives and Ways of Working and the 2010 Framework for NHS Involvement in International Development document) suggest that there is considerable institutional support for IHP within the UK public health sector. These documents also provide evidence that developing countries do respond to opportunities to participate in IHP at multiple levels.

The 2008 DFID Resource Centre evaluation of health links partnerships[6] raises some concerns regarding perceptions of cost-effectiveness of IHP, especially among healthcare managers (in both the UK and partner countries). These concerns may be heightened in the current economic climate. Clearly, the significant increase in resources available to support IHP through the HPS will go some way to addressing these concerns. The management agent will be required to ensure that there is equitable access to these resources through accountable grant mechanisms. It is also intended that the management agent will advise on strategies for maximising cost-effectiveness (for example, through the establishment of NHS charitable trusts); this should include attention to minimising transaction costs and addressing concerns about releasing staff as long-term volunteers. It will also be necessary to provide stakeholders with reliable data demonstrating the mutual benefits of IHP, and to establish M&E systems that will support commissioning of independent cost-effectiveness studies in the future.

The 2008 DFID Resource Centre evaluation of health links partnerships[7] identifies three models of arrangements that have been used to effectively implement programmes of this nature. These include 'management-centred', 'community-centred' and 'minimum-intervention' models. These 'tried and tested' approaches provide a useful spectrum of possible governance arrangements for Health Links Programmes that may be considered in the procurement process.

It is clear that the new HPS programme represents a significant scaling up of resources that will need to be matched by absorptive capacity within the management agency and the health sector in respective countries. The principal role-players will also need to ensure there is appropriate capacity for each activity strand of the programme. For example, the NHS will need to direct capacity to "more ambitious" multi-country work and make provision for releasing staff for longer-term volunteer opportunities. The management agent will need to ensure there is capacity for managing a spectrum of IHP and grant-making arrangements, some of which will include larger programmes that encompass "south-south" as well as "north-south" partnerships; it will also need to make provision for extending appropriate support to a range of volunteers. Meanwhile, more innovative approaches will require appropriate risk management by all parties. Although these challenges are significant, the opportunity for larger, more coordinated programmes means that, with appropriate management and judicious planning, there will also be opportunities for efficiencies of scale based on a manageable number of well-designed, closely monitored programmes.

[6] James et al. 2008. *Op. cit.*
[7] James et al. 2008. *Op. cit.*

Part 2: How the Programme Helps Capacity Building

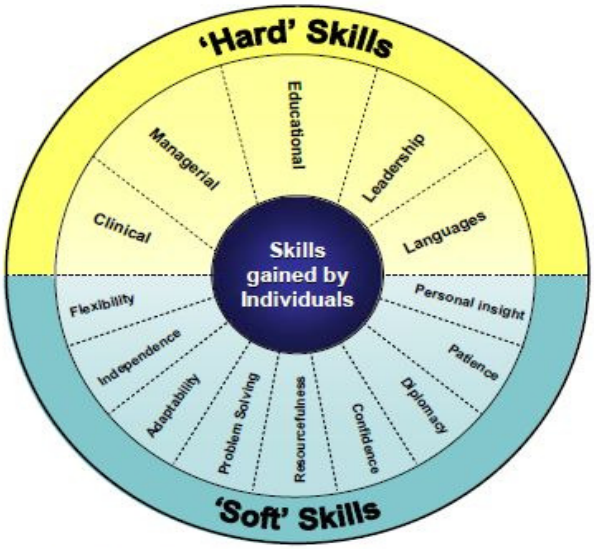

Figure 1: Skills gained by individual health workers

Tribal Newchurch adaptation of Lord Darzi's Next Stage Review (2009)

The *Framework for NHS Involvement in International Development* (2010) draws on a 2009 review by Lord Darzi to illustrate the range of hard and soft skills that can be gained by healthcare professionals participating in international heath partnerships (in the UK and partner countries). These skills include clinical, managerial, leadership cultural and educational skills (see Figure 1 below).[8] These skills can potentially contribute to the quality of services offered to health care users in the UK and partner countries.

Case Study: Capacity Obstetrics and gynaecology in West Timor, Indonesia

Sonia Barnfield is an ST7 Obstetrics and Gynaecology trainee who spent 12 months in Indonesia. Her 'Out of Programme Experience' was facilitated through a fellowship from the Royal College of Obstetricians and Gynaecologists and VSO. Sonia's role consisted of clinical service provision, staff training and implementing a clinical governance infrastructure. Sonia describes the benefits of her year overseas, "I found the experience to be immense – both personally and professionally. Other than the huge clinical experience, I feel I gained many other skills (such as risk management, guideline formulation and resource allocation) which will help me enormously in my career in the UK." Sonia strongly believes in sustainability through capacity building. The staff she trained now perform emergency caesarean sections which has hugely improved the service they offer to the local community.[9]

The DFID Resource Centre evaluation[10] of health links suggests that contributions to capacity building can be strengthened if:

- There is transparency about parallel links or contributions to the same institution so that duplication is avoided.
- Care is taken to ensure capacity building in partner countries is not associated with new services that do not appear in national essential health packages or

[8] Source Department of Health 2010:13 Op.cit.
[9] Source Department of Health 2010:20 Op.cit.
[10] James et al 2008. Op. cit.

local or national plans. There is a danger that these will not be sustainable in the long term or may divert resources away from higher priority activities.
- Support to service delivery is complemented by support for management and system development if country partners feel it is helpful and appropriate.
- UK staff are provided with appropriate orientation training and support prior to and throughout the placement.
- Placements are longer term to consolidate and deepen learning for all parties, and ensure continuity of experience.

In addition, the effectiveness of international health partnerships could be increased by seeking opportunities to move beyond 'capacity building' to more sustainable *capacity development* approaches. UNDPA describes capacity development as building on existing national capacity and priorities by working across three mutually reinforcing levels. These include: the level of individual skills; the level of organisational capacity; and the level of the 'enabling environment' or social institutions.[11] The "capacity development process" also includes the important steps of monitoring, evaluation and systematic dissemination of best practice.

It is suggested that the above recommendations be considered in the procurement process.

[11] UNDP 2008. Capacity Development Practice Note. New York: UNDP