

After the Handshake: What It Really Takes to Share Risk in Place Partnerships

October 2026: jasonbroch.com

The NHS 10-year Health Plan has asked for an ambitious future. The architecture to deliver that vision has also changed tremendously as we move from the traditional commissioner / provider split, into ICBs that are meant to be more strategic purchasers of health & care outcomes and providers (statutory and non-statutory) need to work in an integrated way as place-based provider partnerships. The simplicity of this description belies the complexity beneath. Notwithstanding strategic commissioning is developing itself, there has been little market shaping by previous commissioning to shape what a provider partnership needs to look like or do. We are faced with the need to shape both at the same time and try to understand how we capitalise on previous relationships.

Provider partnerships have formed at place with varying degrees of maturity. I suspect in some places leaders cannot even be in the same room as each other, whilst in others there is profound collaboration. The early days are usually full of momentum and goodwill. Leaders may review a set of broad strategic goals and find common ground. Improving local health, bringing care closer to home, smoothing out patient journeys and tackling health inequalities are ambitions everyone can get behind, but in themselves are quite abstract.

Agreement on paper, however, is the easy part.

The real work begins when that high-level vision meets day-to-day reality—when abstract goals bump up against organisational budgets, statutory accountabilities, operational capacity and a realisation of the risk that partnership work may have on individual partners or indeed the resource implications. Moving from warm consensus to a working partnership isn't about signing another agreement or creating another board; it's about building the trust and practical governance to not just manage, but own risk together.

Moving Beyond Abstract Alignment

It is easy to agree on a phrase like *"integrating community teams & reduce unnecessary hospital stays."* But until partner boards unpack what that actually means on the ground, it remains an aspiration rather than a plan.

To build a partnership that lasts, leaders need space to do the practical groundwork together:

- **Shifting Resources:** Are we truly prepared to move staff, space, or funding from one organisation to another if that's what the pathway needs?
- **Financial Reality:** How do we balance an individual board's duty to balance its own books with a shared commitment to a single local budget?
- **Managing the Ripple Effects:** If acute admissions drop, how do we handle the fixed costs that remain in the hospital while funding the extra demand placed on community and primary care? If we increase discharge by moving staff from hospital teams to community frailty services, how do we cope with additional demand that may find its way to the hospital?

Unpacking these questions early stops boards from buying into a shared vision without realising the compromises required to achieve it.

The Puzzle of Non-Cashable Benefits

When healthcare systems are under severe financial and operational pressure, a common stumbling block emerges: **how we value non-cashable benefits.**

An integrated community intervention might reduce ambulance call-outs, save staff travel time, or free up two hours of clinical capacity per day. In a system stretched to its limits, these gains are hugely valuable. They relieve pressure on staff, improve patient safety, and create vital operational breathing room.

However, freeing up 30 minutes of a nurse's day or avoiding an unadmitted A&E visit rarely translates into actual cash that can be removed from a budget or transferred across a partnership table. Moving a service from 110% capacity to 100% capacity may get us nearer a baseline, but the way the organisation sees that benefit may not be in terms of the investment required to bring that benefit about.

Localised Gain	System Value	Strategic Challenge
Non-cashable savings Time and capacity	Relieves staff pressure Improves patient safety	Cannot easily be transferred or reconciled on a spreadsheet

When finance teams try to reconcile partnership contributions on a spreadsheet, these benefits can feel invisible or "non-reconcilable." Mature partnerships address this tension openly:

- **Recognising Value Beyond Cash:** Accepting that operational resilience, staff retention, and avoided escalation are legitimate partnership dividends—even if they don't lower a budget total directly.
- **Avoiding Real-Cash Transfers for Non-Cash Gains:** Ensuring one partner isn't expected to make hard financial contributions in exchange for soft operational savings elsewhere, unless agreed as part of a wider shared risk pool.
- **Sustaining Upstream Effort:** Recognising community and primary care teams that their work is recognised and supported, even when the benefit they create manifests as avoided cost or absorbed pressure rather than released cash.
- **Statutory Compliance:** The benefit that offers great value to citizens and patients could potentially have an adverse effect on the statutory obligations of a partner.

Getting Comfortable with Shared Risk

A true partnership reveals itself not when things go right, but when unexpected pressure hits. If financial or operational risk stays trapped inside individual organisational silos, partners will naturally retreat behind their own walls when times get tough.

Sharing the Downsides

If a new community initiative takes longer than expected to show results, an acute trust might suddenly face unbudgeted bed pressures. A mature partnership doesn't fall back on contract language or point fingers—it uses pre-agreed risk pools or shared buffers to absorb the shock together.

Sharing the Wins

The reverse is equally true. When a joint initiative succeeds and generates cashable savings or capacity in one part of the system, those resources shouldn't just stay where they land. They need to be shared or reinvested so the team making the upstream effort can sustain and build on their success.

This implies that there needs to be a robust *benefits* / '*dis*'*benefits* approach agreed.

The Courage to Accept Asymmetric Risk

Perhaps the highest level of partnership maturity is when one organisation willingly takes on a bit more risk or operational pressure to help solve a much bigger problem for the partnership.

In traditional healthcare management, success is often defined as protecting your own balance sheet and performance metrics above all else. In a place-based partnership, that mindset can leave the wider system exposed.

Stepping up to absorb risk for the collective good requires three things:

1. **Board Literacy and Trust:** Helping sovereign boards see that taking on localised pressure can be the most sensible decision for overall system stability and patient care.
2. **Mutual Protection:** Creating an environment where an executive team taking a hit for the team feels backed and protected by their partners, rather than left out on a limb.
3. **Agile Governance:** Setting up decision-making channels that can approve quick, practical support when one part of the system is under severe strain.

Fundamentally, the approach to risk, needs to be collective. If a partnership's ambitions are about creating better outcomes and result in less consumption of resources, then partners need to agree how they are going to share the benefit as well as how they are going to share not only the downside risk of the project itself, but the downside risks of partner organisations. **You can't share the upside without sharing the downside collectively.**

Evolving Our Governance Together

To support this way of working, joint governance (although required) needs to feel less like a formal committee and more like a space for collective problem-solving.

Stages of Growth	Early Stage Alignment	Mature Place Partnership
Board Engagement	Approving high-level MOUs	Deep-dive conversations on shared financial and operational risk
Managing Risk	Separate organisational risk registers	A shared place risk register backed by joint mitigation plans
Valuing Benefits	Cash-focused accounting only	Reconciling cashable savings alongside systemic operational relief – through the concept of Value
Leadership Mindset	Protecting institutional interests	Shared stewardship of local population health and care

A Cultural Shift

Governance arrangements and financial models give a partnership its skeleton, but relationships give it life.

If boards only participate when an initiative is risk-free for their own institution, the partnership remains an alliance in name only. Real partnership working is ultimately a human endeavour. It asks leaders to step beyond comfortable boundaries or move them completely, embrace a bit of shared uncertainty, and build the confidence to support one another for the good of the community they serve.