



cutting through complexity

HEALTHCARE

Hospital Collaboration in the NHS

Exposing the myths

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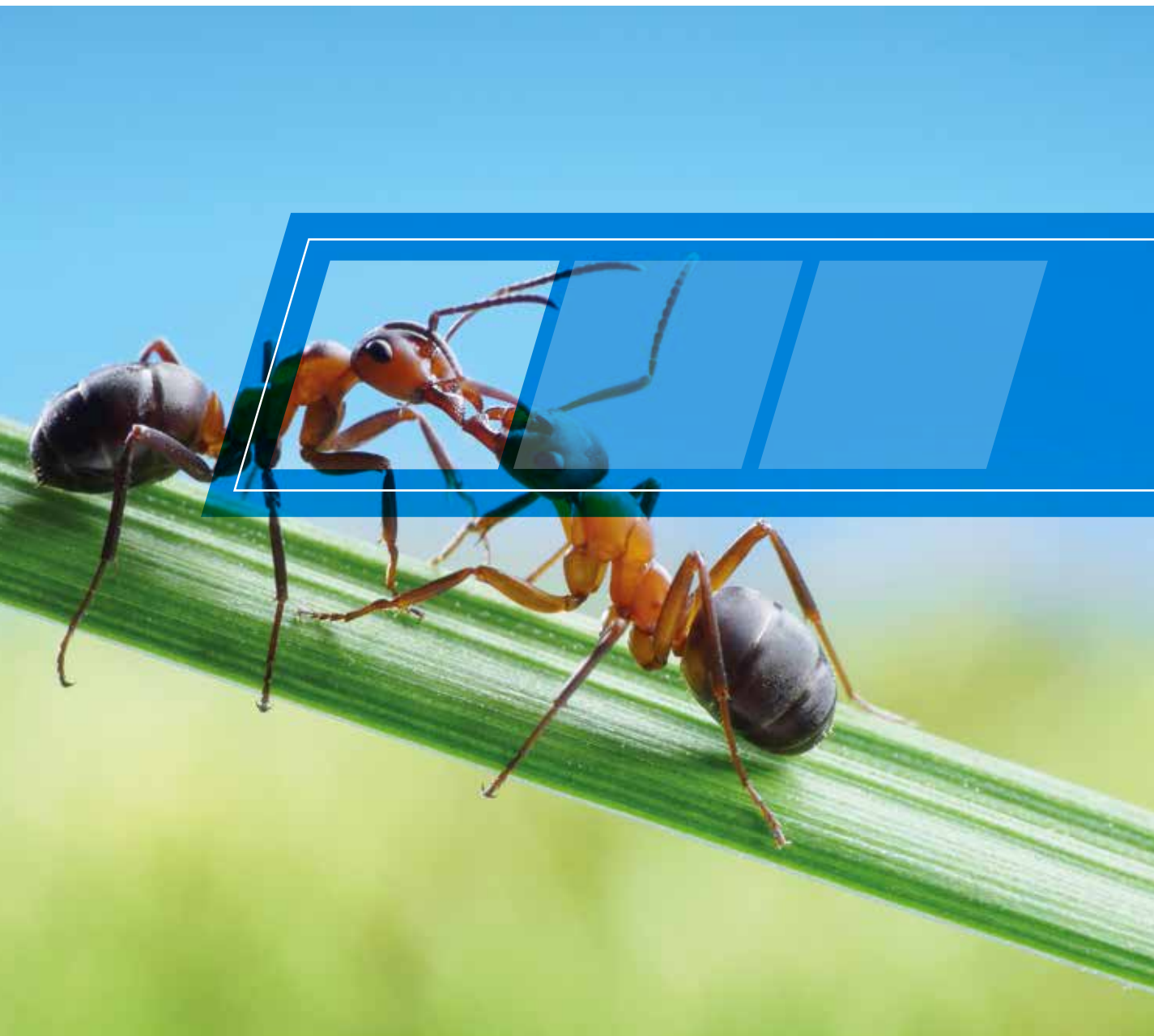
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“Collaboration should be viewed in terms of what’s best for the patient, rather than its impact upon organisational or individual status.”

Sir David Dalton, CEO, Salford Royal NHS Foundation Trust



Collaboration helps providers strengthen their position vis-a-vis commissioners, offers wider services to the local health economy and improve their financial status

01 Foreword

Is NHS collaboration working? Given the rise in mergers and acquisitions (M&A) between Acute and Foundation Trusts, and the enormous effort involved, this question is on many lips. Anyone reading the news could be forgiven for believing that the answer is a resounding “no,” based upon the mainly critical reports.

This paper sets out to expose some of the myths about healthcare collaboration, by presenting the views of those with on-the-ground experience of mergers and other forms of partnerships, not just in the UK but around the world. Along with a KPMG survey of UK Trust Chief Executive Officers (CEOs), the responses build a compelling picture of why hospitals choose to come together, what they expect from collaboration and the reasons for success – or failure.

KPMG in the Netherlands has been carrying out a similar review of collaboration for the past four years, and we augment our findings with some key comparisons from this year’s Dutch publication, which shows that, despite some fundamental systemic differences, many of the issues are international.

According to Anna van Poucke, Partner at KPMG in the Netherlands, the Dutch and UK systems face very similar challenges: “Acute providers in both countries face financial strain, an ageing population, increasing demand and requirements to improve quality of care. Selective procurement by commissioners further increases volatility of turnover. In the Netherlands, consolidation has reduced the number of Trusts by a quarter in the past six years, without reducing accessibility of care. Collaboration helps providers strengthen their position vis-a-vis commissioners, offers wider services to the local health economy and improve their financial status.”

We also pay particular attention to the ongoing challenge of funding, looking at a range of innovative approaches that can help hospitals make better use of their resources.

We would like to thank all the senior healthcare figures that took part in this publication. In our view this document is just the start of a dialogue between all the stakeholders in the system, helping to explore innovative and sustainable models of care in the NHS.



Beccy Fenton
Partner, KPMG in the UK



Matthew Custance
Partner, KPMG in the UK



Executive Summary

Our review of collaboration reveals key trends, ongoing concerns, and pointers to future success:

1. Collaboration remains a high priority

Mergers and other forms of collaboration can enable hospitals to transform care delivery, which explains why around two thirds of the Trusts and Foundation Trusts in our study are, or have been, involved in one or more forms of collaboration over the last year and a half. Quality of care – rather than financial sustainability – is the primary driver.

2. Commissioners and regulators are an increasing influence on collaboration

Almost three quarters of the respondents cite some type of involvement from either Monitor or the Trust Development Authority (TDA) in their collaboration. Involvement of commissioners is even higher. Forty-two percent of hospitals claim to have a mutual agreement with commissioning bodies regarding any collaboration. A further 37 percent informed the commissioner about their collaboration.

3. M&A is on the rise

Mergers are the most intense form of collaboration and are proving increasingly attractive. There were nine deals between 2008 and 2013, and ten in 2014 alone, with a further three being explored. If all transactions are completed, the number of independent Acute Trusts and Foundation Trusts could drop by eight percent from 160 to 147 within just a few years.

4. Many Trusts and Foundation Trusts fail to realise the benefits of M&A...

This is due to a number of factors including: unrealistic expectations of short-term gains; underlying problems that existed pre-merger; unwillingness to invest in the new organisation; a 'winners and losers' mentality that undermines mutual trust; and a lack of attention to cultural integration and good communication during implementation. Nigel Edwards, CEO at the Nuffield Foundation, argues that NHS hospitals do not have "codified management systems" that can be applied to new partners. The challenge is not limited to the UK; 82 percent of respondents to KPMG's study of Dutch hospitals state that they have yet to realise the intended benefits.

5. ...but many have got it right

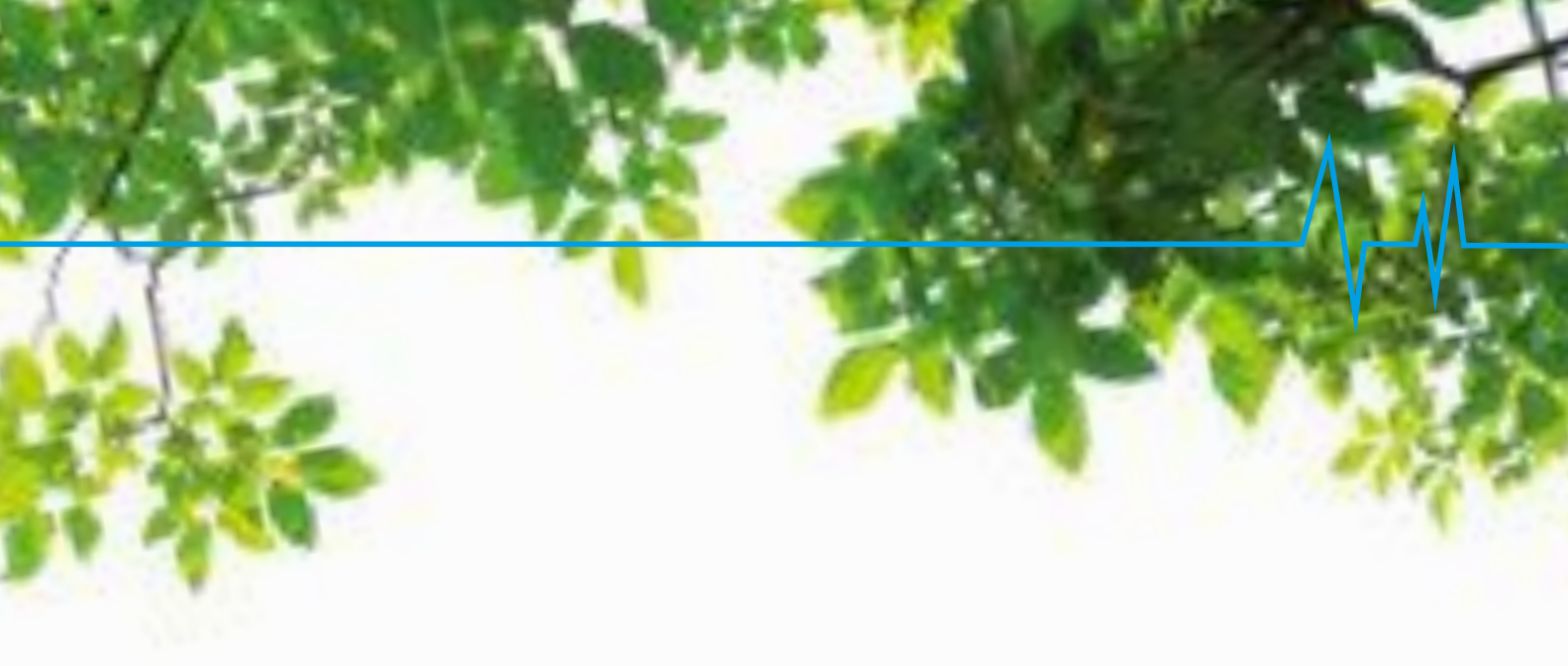
It is easy to forget that many collaborations, including mergers, have yielded extremely positive results. Our review of best practice in the UK and around the world reveals common themes of a strong, experienced leadership team; a shared vision between all parties; clear, regular and consistent communication; and a genuine attempt to build a culture of equality. KPMG's Matt Custance argues that: "Change will only succeed if there is some mechanism, such as a contract, to lock the parties into delivering the transformation." Above all, collaboration needs to be given time, with longer-term clinical benefits taking priority over immediate financial gains.

6. Alternative forms of collaboration are becoming more popular

Sixty percent of respondents in our study are involved in clinical networks, information sharing, joint treatment or diagnostic centres, new shared assets and joint construction of new facilities. Joint ventures, franchises, and cooperatives are also becoming more common. Both the Dalton Review and the NHS 'Five Year Forward View' suggest that the NHS should actively pursue a wider range of care delivery models, and, consequently, organisational forms. In Canada, for example, the state of Ontario has several examples of joint clinical programme management between two or more hospitals, covering specific diseases or clinical interventions. KPMG's Beccy Fenton stresses that: "Ultimately, the type of collaboration should be closely tailored to the type of challenge it is addressing."

7. Collaboration opens up solutions to NHS capital funding constraints

Care transformation requires considerable change to health infrastructure, not least to enable the shift to primary and community-based care. Capital funding is particularly vulnerable, as it does not receive the same protection as revenue funding. The good news is that the funding markets in England are loosening. The gap in public finances provides an opportunity for private finance, despite its detractors, to play a major role offering innovative funding solutions provided by a widening range of financial institutions.



Rather than a classic 'design-and-build' approach, hospitals are leasing facilities that are funded by a widening range of financial institutions. Another option is strategic estates partnerships involving specialist estates managers, with responsibility for planning and managing the entire site, including sourcing capital for essential developments. Collaboration also opens up opportunities to reassess the estate and raise funds to invest in new care models.

8. Collaboration across tiers of care is inevitable

It is not just Acute and Foundation Trusts that will be getting together. Fifty-six percent of respondents are considering collaboration with other organisations in the care system, which could herald joint ventures, franchises, and cooperatives with primary care providers, community and social care providers or private sector organisations.

56%
of respondents
are considering
collaboration with
other organisations in
the care system...

Eight lessons learned to facilitate successful collaboration

Eight key elements of best practice emerge from the experience of the expert commentators contributing to this paper, and the successful case studies:

1. Design the solution to match the problem

The form of collaboration should match the goals and the challenges of the institutions involved and the needs of the local health economy. A merger may be right for some Trusts, whereas others may benefit from looser alliances such as franchises.

2. Prioritise sustainability over short-term financial aims

Collaboration is complex and difficult, and leaders need time to right past wrongs and create successful new working structures and relationships. Ultimate success should be based upon care quality and value, which should be methodically tracked.

3. Ensure that both parties have something to gain...

Create common goals via binding contracts and joint performance targets, to stimulate commitment.

4. Remember, it's all about the patient

Retain a focus on patient care that transcends the egos of leaders and avoids a culture of 'winners and losers.'

5. Engage and communicate with staff

Collaboration cannot succeed without clinical involvement in planning and redesign of services. And it is an unsettling time, and all staff will want to know the progress of the transaction, and, crucially, how it may affect them.

6. Don't underestimate the importance of culture

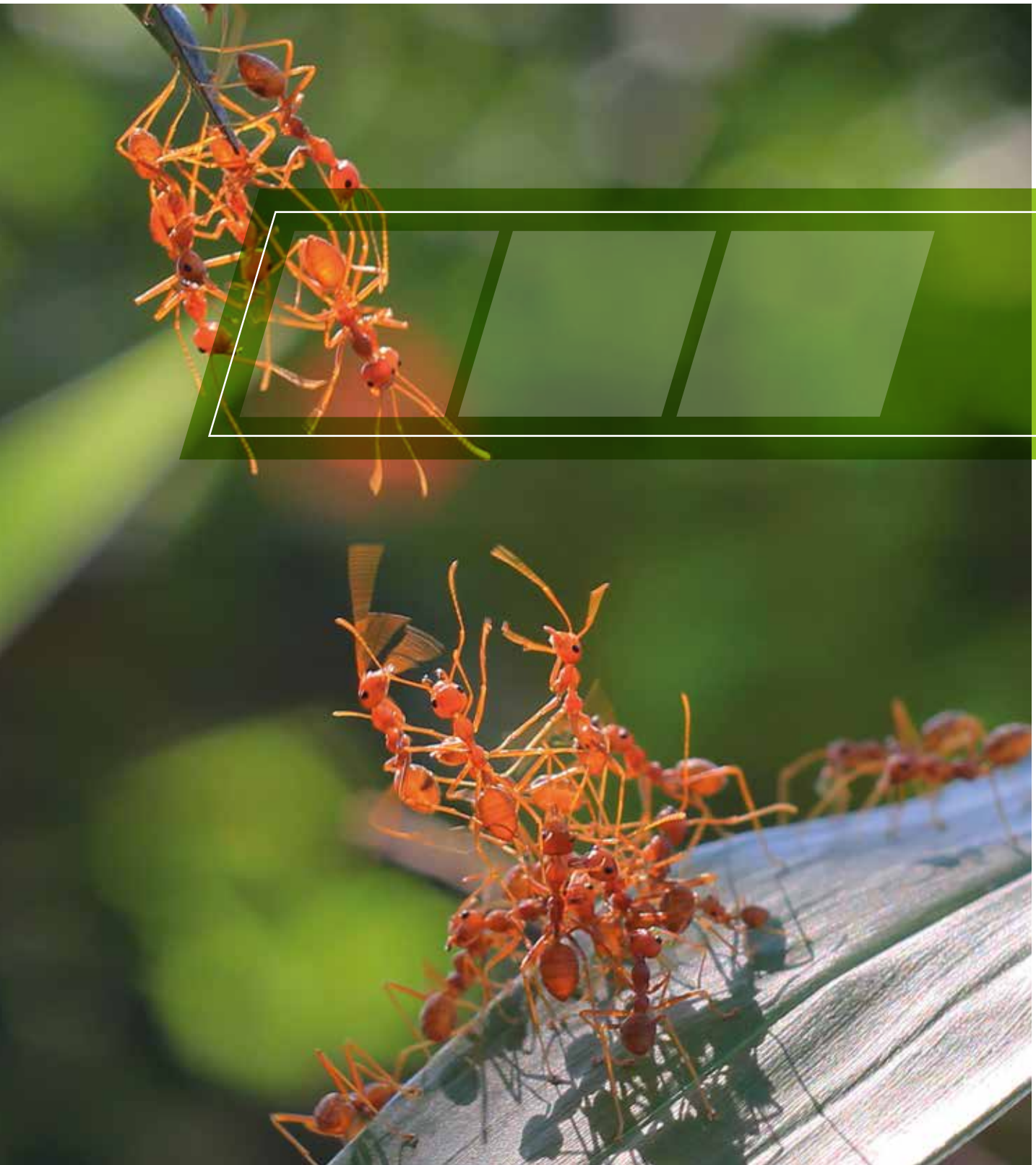
Leaders need to understand cultural similarity differences in order to address divisive sensitivities and hence ways of working to suit all parties.

7. Standardise and codify good practice

It is much easier to transfer standardised, documented operations that are based around people, not processes, as these ensure a common approach to care.


8. Align payment and incentives

New care models should encourage collaboration across tiers of care, such as primary and community, which call for payments and incentives focused on patient value.



“Partnerships should be symbiotic relationships based upon trust. In some cases the contract actually gets in the way of doing the right thing.”

Mark Hackett, CEO, University Hospitals of North Midlands NHS Trust



63% of the hospitals participating in the study are involved in some type of collaboration.

02 Emerging trends

Emerging trends in collaboration among Acute Trusts and Foundation Trusts in England

Our survey responses suggest that collaboration will play a central role in the efforts of Trusts to transform their services, with a rise in M&A and an increasing willingness to embrace new types of partnerships. And, with commissioners and regulators getting more involved with M&A, leaders have to liaise closely with these bodies to ensure a smooth path to implementation.

This section examines organisational motives for collaboration, and looks at some of the barriers to success, such as an obsession with short-term gains, a lack of mutual cultural appreciation and a 'them and us' mindset. We also summarise the 2014 Dalton Review and present an interview with its author, Sir David Dalton, who argues that consolidation aids efficiency, and urges Trusts to consider the widest possible types of collaboration, in addition to mergers.

Collaboration is high on the executive agenda

- Seventy six percent of respondents envisage collaboration within the next three years
- Trusts need a compelling reason for collaboration
- A formal, contractual agreement can increase commitment from both parties.

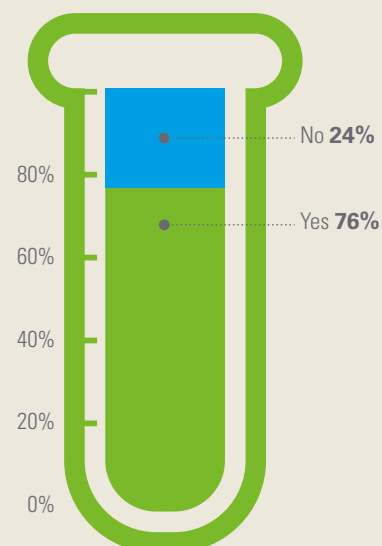
NHS hospitals have been collaborating for a variety of reasons for many years. They choose from a range of forms, both formal and informal, including full M&A, clinical networks, procurement alliances, joint treatment or diagnostic centres, and information sharing.

Of the Trusts participating in our study, 63 percent are taking part in some type of collaboration, and 16 percent are, or have been, involved in a merger or acquisition since January 2013.

Looking ahead to the next three years, three quarters expect to work together with other institutions, with the most popular choices of collaboration being clinical networks, joint procurement, cooperative forms and healthcare logistics such as joint information for the purpose of planning, and exchange of patient related data.

In the corresponding survey of hospitals in the Netherlands, almost half of the respondents are engaged in a collaboration, with 13 percent carrying out an acquisition and 30 percent involved in a merger.

Do you expect to look for a collaboration partner in the next three years?



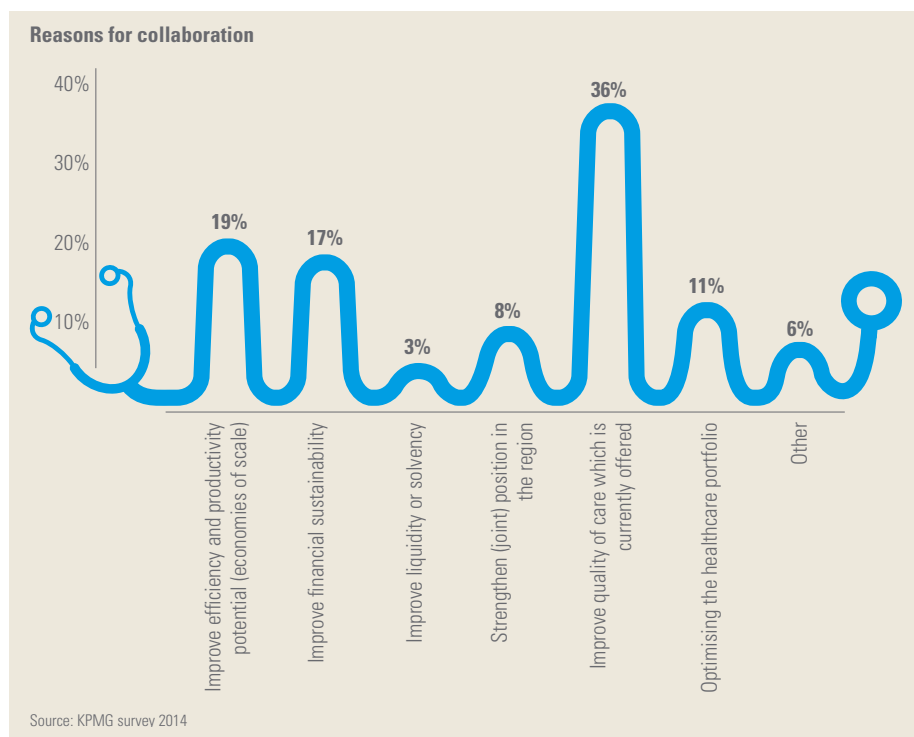
Almost three quarters of respondents say that either Monitor or the NHS Trust Development Authority (TDA) were involved in their collaboration, and **79%** state that commissioners had some form of input.

Quality of care is the prime driver behind collaboration

The chart below shows that the single biggest reason for collaboration between NHS organisations is to improve the quality and safety of care. Efficiency and productivity improvements are some way behind in second place.

Only 17 percent of respondents cite financial sustainability as the key rationale. KPMG's 2015 survey of Dutch healthcare organisations mirrored these findings, with quality of care also considered the number one factor.

In the following two sections, we bring together two perspectives on collaboration from KPMG partners in the UK, Roberta Carter and Matthew Custance.



Only
17%
of respondents cite
financial sustainability
as the key rationale
for collaboration.



The why is more **important** than the **how**

Roberta Carter, Partner, KPMG in the UK

NHS trusts have a much greater chance of collaborating successfully if they remember why they are working together, and only then worry about how to structure the new entity.

Too many NHS healthcare mergers were failures in the 1990s for that very reason. In many cases, hospital administrators simply grafted together two management structures, and only later brought together back-office functions. In some cases, the divisions between distinct front-line services remain visible to this day.

These were often publicly-mandated mergers, motivated for political reasons. By contrast, today's successful collaborations have a compelling clinical rationale at their core, underpinned by commercial and financial rigour.

I'm glad to say an increasing number of collaborating trusts are getting the message, perhaps because they have to. NHS staff are working under far greater pressure than 20 years ago. Budgets are stretched and the need to be more efficient and streamlined is more urgent. The logic of collaboration, and the need to make it a success, is compelling.

In the successful deals I've worked on, in both the public and private sector, the strategic rationale has always been clear.

The NHS is one of the sacred cows of British politics and any change will inevitably face entrenched positions, such as political opposition and scepticism from clinicians who may not understand the benefits for patients. We all instinctively oppose change and want to protect local services. Even as hundreds suffered poor care or died early in Mid-Staffordshire, people were waving 'Save Our Hospital' banners outside. Leaders must make sure they properly articulate why collaboration is in the public interest and ensure they have backing from clinicians.

Once trusts have decided to collaborate, they need to do so whole-heartedly and at every level. For that reason I see mergers – rather than joint ventures or alliances – as the most successful form of collaboration.

Joint ventures might endure for decades, but neither party is fully committed. The merger model is far more comprehensive and the best way to achieve big transformational change.

Mergers offer organisations synergies, so duplication and overlap are stripped out. More importantly, they bring together services that might previously have been provided by a number of organisations, giving doctors and nurses greater consistency and control across patient pathways.

Whatever the form of collaboration, its success depends on integrating information and ensuring all clinicians have complete access to their patients' holistic care plans and records. While investing in IT might seem less exciting than M&A, it is nonetheless a fundamental enabler for efficiency and patient safety. It also makes it easier to move activity out of hospitals and into the community, the home, a GP surgery or elsewhere.

The NHS is already very skilled at collaborating across boundaries such as the Academic Health Science Centres and cancer networks. But if trusts are trying to drive transformational change then a merger will produce results much faster. In an environment of ever greater demand and smaller budgets, properly thought through collaboration is essential to deliver higher-quality healthcare.



Going **legal** enhances the chance of a successful **partnership**

Matthew Custance, Partner, KPMG in the UK

Roberta may be right that the why is more important than the how, but getting the how wrong can still destroy your chances of success. It's my belief that formalising collaboration, when done well, delivers the twin benefit of bringing clarity and locking in commitment, even when times get tough.

The beauty of the merger process is therefore that, by binding two organisations together, you make a big statement to the old organisations about removing responsibilities to the old organisations and tie all levels of management and staff into a shared responsibility which spans both former organisations. It's very difficult on the one hand to be employed by Organisation A – and have a legal responsibility to that organisation – and yet still promote a programme that perhaps leads to benefits which may largely flow to staff or patients of Organisation B. Imposing a single corporate and management structure, through a merger, removes these barriers and makes it easier for staff and management to ask "What is best for all our patients, all of our combined system?"

So, where it is practical, I think this is the form of collaboration that stands the best chance of success in an NHS environment. The first responsibility of any stressed NHS executive is to his or her own organisation. If a collaboration is not beneficial to their organisation, it will quickly be abandoned.

So redefining organisational boundaries is an important part of getting people to collaborate.

If a merger is not right for the deal, the next best option is generally to build a shared responsibility via a joint venture. Such a move creates a corporate or contractual arrangement between two parties, as well as a forum to discuss the collaboration, formalises regular discussions that otherwise would struggle to find a place in busy senior people's diaries.

JVs are a simple way of regulating collaboration, and we have already seen a number of successful examples between NHS and private bodies, aimed at managing estates better or reducing costs.

It was only with the creation of Foundation Trusts in the early 2000s that JVs became possible, but their effectiveness is already clear. The Brompton, Marsden and Chelsea & Westminster Trusts are already sharing back office functions such as Human Resources (HR) and Finance.

The next best option is a legally-binding contract. It may seem cynical, but if you have invested scarce time and money, then you need to be protected by an agreement that ensures your partners also contribute. Numerous examples of this type of collaboration exist both within the private sector and in the form of service level agreements in place throughout the NHS.

NHS managers tend to go into collaborations to solve a problem in their specific institution, but this can only happen if both parties have a mutual interest in each other's prospects. Stronger, formal ties can only enhance the prospects of success.



“A standardised, lean, continuous improvement methodology would enable the NHS to deliver much greater value for money, improved quality and higher staff morale.”

Beccy Fenton, Partner, KPMG in the UK

A more pervasive role for commissioners and regulators

Working with Monitor, the Trust Development Authority, commissioners and NHS England should ensure a smoother route to collaboration.

Both Monitor the sector regulator for health services in England (which regulates all Foundation Trusts) and the NHS Trust Development Authority (TDA, which oversees non-Foundation Trusts that remain directly accountable to the NHS) are taking a greater interest in collaboration and have set out detailed transaction guidance.

Trusts and Foundation Trusts must adhere to these protocols to ensure that any mergers or other partnerships work in the best interests of the public.

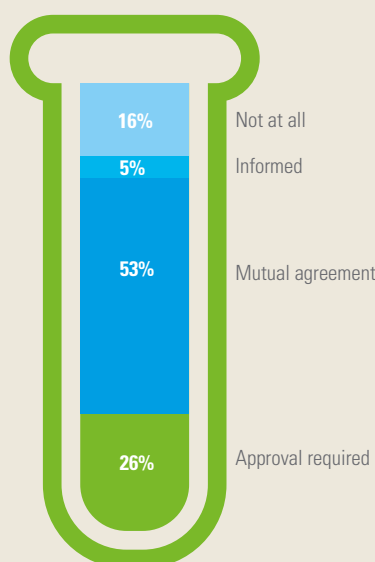
Our study reflects this trend, with almost three quarters of respondents citing some type of involvement from these two bodies. Fifty-three percent say they “informed” Monitor or the TDA when considering a collaboration, and in 26 percent of cases, approval was required.

37%
informed the
commissioner about
their collaboration.

When it comes to commissioners, the involvement level is even higher. Forty-two percent of hospitals claim to have a mutual agreement with commissioning bodies regarding any collaboration, and a further 37 percent informed the commissioner about their collaboration.

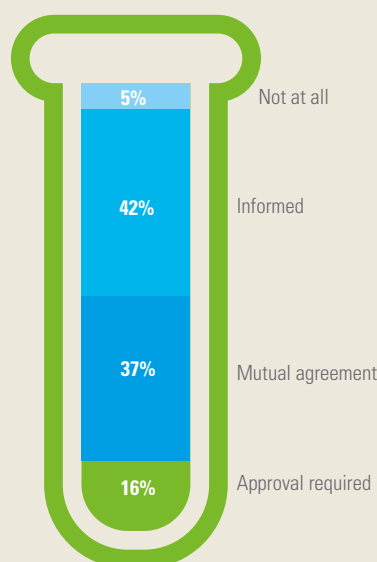
A similar trend is apparent in the Netherlands. Banks and health insurers, with the latter acting as commissioners, are playing a greater role in hospital collaboration. Moreover, the Authority of Consumers and Markets (ACM) is increasingly intervening to question the viability of certain mergers, on the grounds that they are not in consumers’ best interests.

Type of involvement Monitor or TDA



Source: KPMG survey 2014

Type of involvement commissioners



Source: KPMG survey 2014

The **importance** of a common vision

Anne Gibbs, former Deputy CEO, West Middlesex University Hospital NHS Trust

One of the most important things that I've learned is how crucial it is for the Boards on both sides to set the right tone. There needs to be a shared vision, a positive mindset and mutual respect. This is fundamental for the joint working that these transactions need if they are going to deliver the benefits all parties want to see.

For example, in some cases, the acquiring leadership has been very critical of the Trust being acquired. This approach can be very challenging for staff and clinicians. It sets a really poor foundation for the future relationship and integration plan.

It's also misguided. In the majority of cases, the hospital being acquired will have areas of good clinical practice and dedicated, hardworking staff. Ignoring this is not only unhelpful but it can close off opportunities to promote the best that each organisation has to offer. Success means acknowledging both each other's strengths and weaknesses.

It is often the case in organisations being acquired that they have had several years of uncertainty regarding their future. The leadership of the Board, to both continue to deliver a complex business as usual agenda alongside a transaction process is key.

These Boards need to be well supported to deliver an optimal solution for the future delivery of healthcare and to promote the benefits of merger to its staff and patients.

An open management approach to a merger or acquisition will improve the chances of success. That means openness and respect for the merger partner, as well as recognition of the role of other players in the system. In the better examples of merger, the senior management of the acquirer recognises the importance of working with Monitor, the NHS Trust Development Authority, commissioners and NHS England, to design a successful unified transaction process.

The increasing popularity of M&A

- The number of Trusts/Foundation Trusts in England could drop by as much as eight percent in the next few years
- Many sites have changed their function post merger
- Trusts should create a culture of equals, not winners and losers.

M&A activity is on the rise in particular are on the rise. From 2008 to 2013 there were nine such transactions, whereas ten have been undertaken during 2014 alone, with a further four being explored by Trusts seeking to address challenges through formal integration. This surge in M&A activity could (if all transactions are completed) reduce the number of independent Acute Trusts from 160 in 2014 to 147 within a few years – a drop of eight percent.

In the Netherlands, similarly the volume of mergers has been high, with 18 completed between 2009 and 2014, and an additional 11 in consideration at the beginning of 2015 (three of which are uncertain). Consequently, the number of independent Acute Trusts could plummet by as much as a quarter from the 2009 figure of 116, leaving just 87.

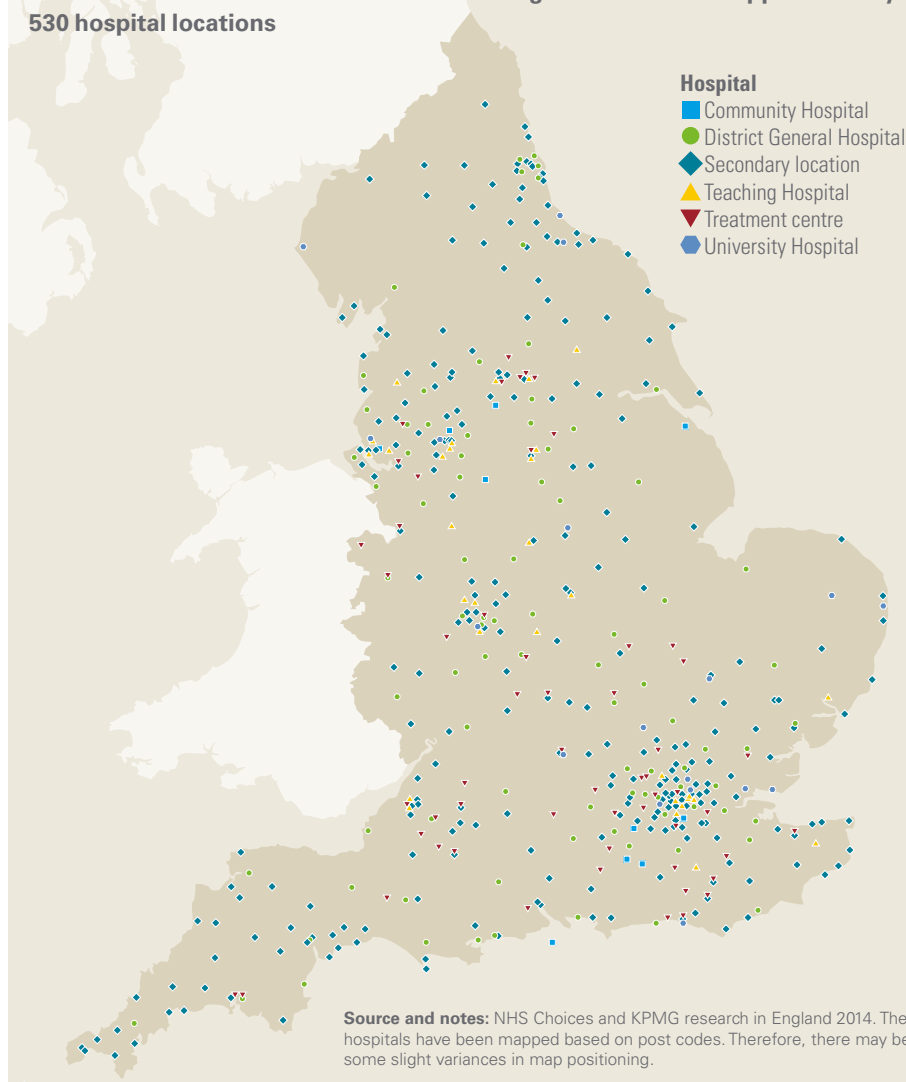
Although the number of hospital locations in the Netherlands has not reduced dramatically, the function of many of the sites has changed, reflecting the rationale behind many mergers. These trends can be expected to evolve in England as well and will be compared over time in future reports. In the Netherlands, however, attempts to fundamentally reorganise services across sites have been relatively unsuccessful.

Declining numbers of independent Trusts/Foundation Trusts in England (Expected) decrease numbers of independent Acute Trusts / Foundation Trusts



Sources: KPMG desktop research and survey 2014

Care of Acute Trusts / Foundation Trusts in England is offered in approximately 530 hospital locations



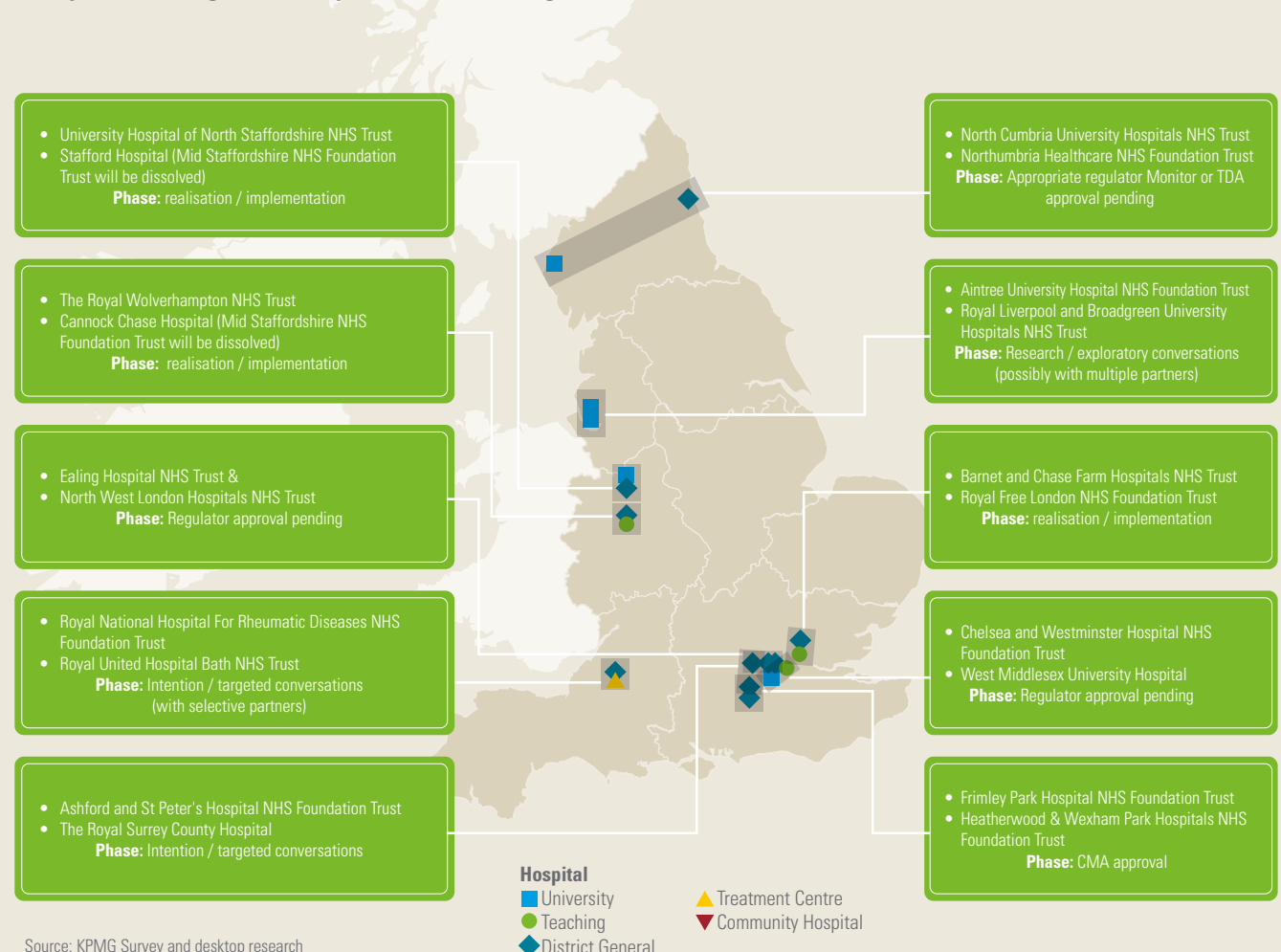
Types of hospital (England)



“Change will only succeed if there is some mechanism to lock the parties into delivering the transformation.”

Matthew Custance,
Partner, KPMG in the UK

A snapshot of mergers and acquisitions across England





Understanding the **scale** and **impact** of mergers

Nigel Edwards, Chief Executive, the Nuffield Foundation.

It's dangerous to think of mergers as an instant solution, as they also represent a huge pull on resources and create considerable cultural and operational displacement. The perceived lack of post-merger benefits is partly due to the lack of a strong, clinical rationale for M&A, with leaders preferring to merge now and sort out strategy later, rather than vice versa.

Other sectors spend more time and energy upfront on due diligence and pre-integration planning, helping to identify synergies and establish roles and responsibilities. Another obstacle is a lack of codified management systems in NHS hospitals, something identified in the Dalton Review.

You can't take over or merge with another organisation if you don't already have a clear, documented way of doing things yourself.

Mergers are not the only option. The 'swap' between University College London Hospitals NHS Foundation Trust (UCLH) and Barts Health NHS Trust (with the former's cardiovascular services moving to a brand new centre at St Barts, and specialist cancer services going in the opposite direction) was an amazing piece of strategic change brokered by five different organisations, all working together based upon a memorandum of understanding. The advantage of such an alliance is that hospitals do not fully integrate and only align certain areas, which is far less of a distraction.

Some hospitals – notably Moorfields Eye Hospital NHS Foundation Trust and Dartford & Gravesham NHS Trust – have even established networks to provide franchised services in distant locations. This works best for relatively simple services, but for complex treatment such as cardiac surgery, it is harder to assure a consistent quality of support.

Trust is often a better starting point than the short, sharp shock of full integration. Over time, organisations with looser alliances may choose to share functions such as accounts, procurement and additional clinical services, and possibly move to single governance. This is definitely happening within primary care, where GPs are asking others to take over responsibility for their practices.

Location of mergers /and acquisitions in which the partner is undetermined



Source: KPMG survey and desktop research

M&A: Barriers to success...and how to overcome them

- Many problems and costs attributed to mergers are actually pre-existing
- The acquiring leadership is often critical of the hospital they're taking over.

Success should be measured in terms of long-term care quality. In common with many M&A in the corporate world, the planned benefits of mergers in the NHS do not always materialise. KPMG's global study of healthcare M&A *Taking the Pulse*¹ found seven common factors behind successful transactions:

1. Select new leaders and let them lead
2. Create and communicate a strong, clear vision
3. Place an emphasis on planning
4. Do the due diligence
5. Win over key stakeholders
6. Develop both the structure and the people
7. Have patience to achieve long-term objectives

Past NHS M&A activities have focused on short-term improvements in operational and financial performance, often at the expense of more defined, integrated strategies that will bring lasting benefits. Optimistic or even unrealistic expectations of immediate gains can mask the real cost of implementation, and it sometimes seems as if commissioners have neither the will – nor the capacity – to invest in a sustainable future for newly-merged organisations. Consequently, they often overlook opportunities to provide access to capital for investment in 'spend-to-save' schemes that are designed to bring efficiencies.

¹ Taking the Pulse, a global study of mergers and acquisitions in healthcare, KPMG International, 2011.

A close-up photograph of several ants on a green leaf. The ants are orange-brown and are moving across the leaf. A white rectangular frame is overlaid on the image, and a green line with a jagged, heartbeat-like pattern extends from the top right corner of the frame.

82%

of respondents to KPMG's study of Dutch hospitals state that they have yet to realise the intended benefits of a merger

Through robust due diligence, an NHS merger will frequently also uncover major latent problems, such as a poor estate which is not 'fit for purpose,' which has been adversely impacting one or both of the hospitals for some time, and inevitably requires some additional investment to overcome. Such challenges, and associated costs, are often wrongly attributed to the merger itself they are, in fact, the result of longstanding issues that only came to light when the two organisations came together.

The attitudes of the leadership can also undermine integration efforts, with the acquiring hospital's management often adopting a 'superior' mindset, even in cases where its clinical performance is worse than that of its new partner. Anne Gibbs, Transactions Director, London, NHS Trust Development Authority, observes that: "In some cases, the acquiring leadership has been very critical of the Trust it is taking over, alienating clinicians and management and setting a poor foundation for the future relationship."

M&A in the Netherlands: main stumbling blocks

Creating a successful merger is a huge challenge, as evidenced by the fact that 82 percent of respondents to KPMG's study of Dutch hospitals state that they have yet to realise the intended benefits. One major hurdle is a lack of focus on the long-term, with significant effort devoted to the approval process, and not enough resources allocated to subsequent integration.

Governance was another barrier to progress. In the majority of Dutch hospital mergers, the executive team was combined, yet the two organisations remained separate legal entities, which can restrict efforts to gain synergies and develop closer working relationships. Some merged organisations failed to show significant advantages (such as an increased range of services to patients), indicating that the rationale for the merger had not been fully thought through. And finally, in cases where consultants are self-employed, they may be less keen to work with new partners.

"NHS hospitals do not have codified management systems. You can't take over or merge with another organisation if you don't already have a clear, documented way of doing things yourself."

Nigel Edwards, CEO, the Nuffield Foundation



The shocking truth about **mergers** is they actually work

Carwyn Langdown, Executive Advisor, KPMG in the UK

Mergers are grossly misunderstood. Anyone reading the British press would believe that nearly every M&A is a failure. This bad news overshadows the success stories and fails to bring to light the severe, underlying difficulties that NHS mergers typically have to overcome.

There are some fantastic examples of successful hospital mergers, such as Guys and St Thomas Foundation Trust, which is now seen as a single entity by both NHS staff and the general public. Similarly, the well-respected University College London Hospitals NHS Foundation Trust, also the result of a succession of mergers, appears to be too much of a good thing to make the front pages, which prefer to root out bad news. The first ever Foundation Trust acquisition saw Heart of England NHS Foundation Trust acquire and merge with the struggling Good Hope Hospital Trust.

This collaboration delivered a major turnaround in the unsustainable financial position at Good Hope, and also enabled significant capital investment in new inpatient facilities and equipment. Beccy Fenton, Deputy CEO and Chief Finance Officer Director at the time of the merger, recognises that “clinical and cultural integration probably took second place to the financial aspects of the transaction, and the lack of interstation in these areas still appears to create issues to this day. Clearly, future M&A must pay sufficient attention to these ‘softer’ areas as well.”

While there have been failures in the past, I don’t think these were because of the merger itself, but rather a fault in the design of the process that the merging organisations went through. Mergers are often seen as a panacea that will solve a problem; the end of a process rather than the beginning.

The pressure on management to deliver immediate savings often leads to a lack of vision about the ultimate organisation and service delivery they want to create. Under such conditions, it’s little surprise that so many leadership teams hardly get past first base.

Terminology is partly to blame, as the term “merger” is often incorrectly used to describe enforced acquisitions caused by a failure in one hospital. Keen to avoid the aggressive-sounding “acquisition,” Trusts, regulators and commissioners mislead us into thinking that both parties entered into the venture of their own free will.

The timeframe to embed cultural integration is vastly underestimated. Success should ultimately be measured in terms of the quality of service that’s being delivered, as well as long-term financial and operational sustainability. Whether the merged Trust is instantly profitable is far less important than whether it is a sustainable model going forward.

Collaboration should be about **better healthcare** for patients

Mark Rochon, Associate, KPMG Canada and KPMG's Global Centre of Excellence

Many of today's hospital and broader health care system structures are not fit for purpose and fail to meet the needs of patients, particularly those who have multiple co-morbid conditions and require care that spans the continuum of service. Payers too are looking to improve the value proposition of health care and are causing providers to examine alternative organizational relationships. Collaboration in one form or another is vital for a sustainable system.

Successful organizational relationships consistently exhibit a clear shared vision that can be achieved by working together. One stumbling block to success is the lack of a shared vision; if you don't understand what you're trying to achieve, you cannot move forward together. The concept of winners and losers is especially harmful. Collaboration should be about better healthcare for patients, not what organisation "won or lost".

In many respects getting through the execution of the transaction to implementing the integration is another important ingredient for success. Organizations with impending mergers often exhibit organizational paralysis and risk losing key staff who fear for their futures while the transactional aspects of the merger take place. The parties should never short change appropriate due diligence; however, the real work and benefits come after the transaction is executed.

Compared to the UK, Canadian provinces such as Ontario have fewer hurdles to clear enabling shorter time frames through to deal execution. I was involved in one merger, as Chief Executive, where the time from concept to execution of the transaction was just five months, without compromising due diligence processes.

Culture is an important element of successful organizations. Understanding the cultural differences and similarities between partners is key to a successful future. Developing shared values and promoting those values through education, development and performance expectations will over time create the conditions for a shared sense of purpose.

Staff associated with organizations about to undertake a merger are understandably worried about employment. Developing labour adjustment policies and practices that promote fair treatment of employees will help reduce the anxiety associated with these undertakings.

Consistent, thoughtful and frequent communication to all key stakeholders within and beyond the organization is critical. Being clear about the vision and rationale for change, expected benefits, time frames and so forth is key.

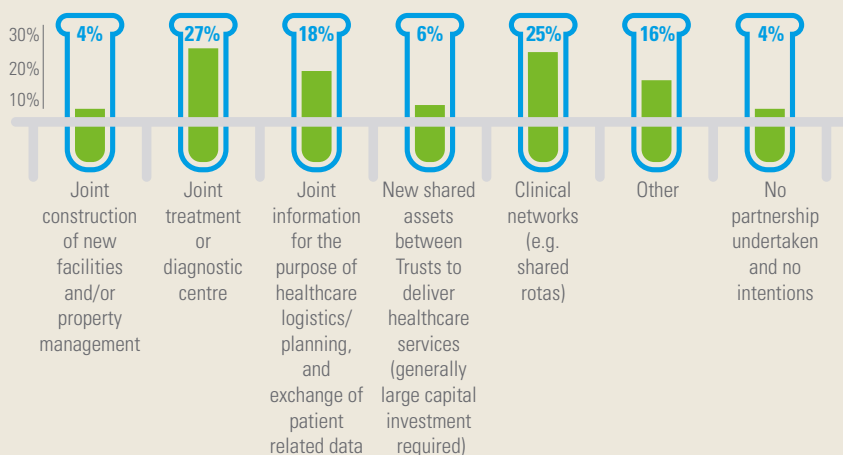
While mergers are one way to achieve collaboration, there are others including joint clinical program management.

Toronto's renowned Hospital for Sick Children jointly manages the surgical cardiac programme with the smaller Children's Hospital of Eastern Ontario in Ottawa, 350 kilometres away. A robust triage system channels patients to the appropriate provider, giving them access to world class treatment, and overcoming risks associated with low volume providers.

Another alternative is to achieve collaboration is through system or province wide oversight structures. The Cardiac Care Network of Ontario establishes standards and advises the payer about capacity, wait times and quality. Cancer Care Ontario has a similar purpose but also acts as the purchaser of the majority of cancer services offered in Ontario enabling appropriate aggregation of resources.

A further option is joint governance, which can be effective in cases where two hospitals don't necessarily want to merge, yet share a common desire to work together. A single executive structure with delegated authority oversees the operation of the two entities. Finally, hospitals in difficulty may benefit from the support of management expertise from more stable peers who under contract provide executive leadership to the troubled organization. Although a temporary arrangement, such relationships can form ties that could later lead to more formal collaboration.

Other forms of collaboration undertaken other than M&A



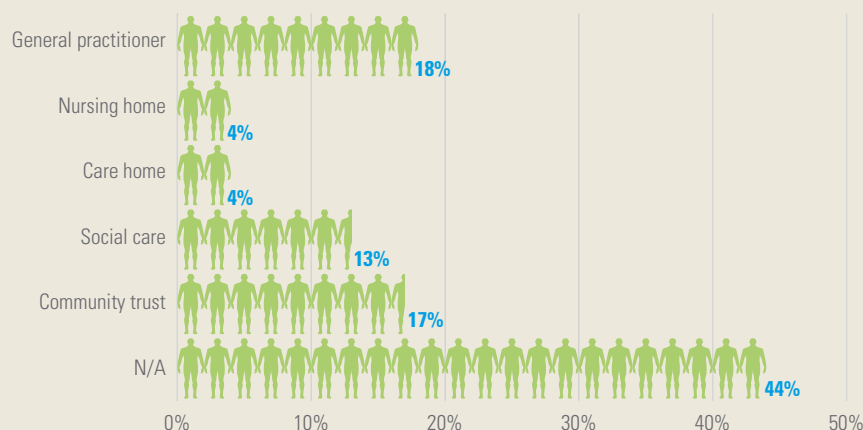
Sources: KPMG desktop research and survey 2014

Trusts looking for a partner to collaborate with in the next three years



Source: KPMG survey 2014

Collaborations of Acute Trust / Foundation Trust with other organisations in the care system



Source: KPMG survey 2014

A growing appetite for alternative forms of collaboration

- Hospitals are starting to undertake collaboration across tiers of care
- Trusts should ask whether their existing form is right for delivering new care models
- Standardisation and codification creates a foundation for smoother integration.

Mergers and acquisitions are by no means the only option, and many Trusts around England have entered – or plan to enter – into other forms of collaboration. As Nigel Edwards, Chief Executive of the Nuffield Foundation, says: ‘When you’re talking about collaboration, the first question has to be: “What problem are we trying to solve?” and choose the appropriate form of collaboration to address the challenge.’

Sixty percent of the respondents in our study are involved in one or more initiatives such as clinical networks, information sharing, joint treatment or diagnostic centres, new shared assets and joint construction of new facilities.

English Trusts and Foundation Trusts are also exploring the possibility of other forms of collaboration such as joint ventures, franchises and cooperatives, particularly across tiers of care. This may involve partnering with primary care providers, community and social care providers or private sector organisations. Of the Trusts participating in the study, more than half (56 percent) are looking to collaborate with other organisations in the care system.



Exploring different organisational and collaborative models

In a historic move in 2012, Hinchingsbrooke Health Care NHS Trust became the first public hospital to delegate management functions to a private company via a franchise with Circle Partnership. Although the hospital is managed privately, the buildings are still under public ownership by the NHS and the staff remain employees of the NHS Trust. In early 2015, Circle announced plans to pull out of its 10-year contract, citing that “unprecedented [accident and emergency] attendances”, insufficient bed spaces for demand and significant funding cuts had undermined its efforts to maintain high clinical standards².

Despite the apparent lack of success of this particular initiative, further partnerships of this nature may well emerge in the UK, taking into account any lessons learned from early adopters.

Amongst others, Moorfields Eye Hospital NHS Foundation Trust has established a network of 28 clinics across London, and has ventured into overseas franchises. In this model, Moorfields offers ophthalmological services by collaborating with hospitals through formal contracts, mainly in and around London. Great Ormond Street Hospital for Children NHS Foundation Trust has also branched out beyond the UK.

Another example is South Devon Healthcare NHS Foundation Trust’s merger with Torbay and Southern Devon NHS Health and Care Trust. It is the first ever case in the UK of an Acute Trust and a health and social care trust coming together to form a comprehensive, integrated health and care service. The new organisation plans to act as a ‘one-stop shop’ to provide support as close to home as possible.

“Leaders need to break out of the single hospital mindset, and recognise that collaboration brings better services at lower costs.”

Sir David Dalton,
Chief Executive,
Salford Royal Hospital
NHS Foundation Trust

56%

are looking to
collaborate with other
organisations in the
care system.

² Circle to withdraw from Hinchingsbrooke Contract, Health Service Journal, 9 January 2015.

Mergers or acquisitions: Acute & community

- South Devon Health Care NHS Foundation Trust
- Torbay and Southern Devon Health and Care Trust

Phase: Appropriate regulator Monitor or TDA approval pending

- Hospital**
- University
 - Teaching
 - ◆ District General
 - ▲ Treatment centre
 - ▼ Community Hospital
 - Community Trust

Source: KPMG Survey and desktop research

Five key themes of the 2014 Dalton Review

1. One size does not fit all
2. Quicker transformational and transactional change is required
3. Ambitious organisations with a proven track record should be encouraged to expand their reach and have greater impact
4. Overall sustainability for the provider sector is a priority
5. A dedicated implementation programme is needed to make change happen.

Despite the growing popularity of collaboration in England, the 2014 Dalton Review² suggests that the NHS could accommodate a wider range of organisational forms. These forms include buddying, informal partnering, clinical and strategic networks and mutual or social enterprises such as joint ventures, management contracts, integrated care organisations and mergers and acquisitions.

As the review notes: "It is rightly stated that 'form follows function.' Organisational form should always be designed to support the delivery of models and standards of care, and should not be an end in itself. This Review encourages boards to consider fundamentally whether their existing form is best designed to deliver new models of care and ensure the delivery of required standards."

The 2014 NHS 'Five Year Forward View'³ expresses similar sentiments, calling for a variety of collaborations. These include: integrated hospital and primary care systems that combine general practice and hospital services (along the lines of accountable care organisations); and partnerships between smaller hospitals and local specialist hospitals as well as hospitals further afield. A further suggested option is integrated out-of-hospital care involving GPs, nurses, other community health services, hospital specialists, and even possibly mental health and social care.

² Examining new options and opportunities for providers of NHS care, The Dalton Review, December 2014. Authored by Sir David Dalton, Chief Executive, Salford Royal Hospital NHS Foundation Trust.

³ NHS Five Year Forward View, October 2014.

Innovative forms of collaboration – two examples of a takeover in the Netherlands

In the Netherlands, a number of hospitals have formed highly innovative cooperatives to rescue bankrupt Trusts, spreading the risks across a number of organisations, and giving smaller Trusts the opportunity to expand their influence.

The survival of **Zorggroep Pasana–Sionsberg Hospital**, an Acute care Trust that also provided community care, was in doubt until three other providers came up with the radical 'Sionsberg 2.0' plan to combine primary care, community care, outpatient, day case and care at home. Crucially, the initiative has the support of De Friesland Zorgverzekeraar, the region's most important commissioner, in the form of a contract with Sionsberg 2.0 that could extend to five years.

Each of the providers brings something unique to the new entity, augmenting Sionsberg's existing 24-hour GP services and pharmacy with:

- Diagnostic, outpatient and day care services provided by DC Klinieken
- Community care offered by ZuidOostZorg
- Cardiologie Centra Nederland delivering cardiology outpatient and day care.

Bankrupt hospital **Ruwaard van Putten** was in a precarious position in 2013. A poor reputation, caused by high mortality rates in its cardiology department, had reduced demand and income to the point that it was unable to pay its employees. In this instance, the three Trusts that together took over the hospital chose to significantly change the service offering, with weekday-only clinics and a focus on planned care.

Despite concern by banks and commissioners over the high cost of refinancing capital, the cooperative, consisting of Maasstad ziekenhuis, Ikaza ziekenhuis and van Weel-Bethesda, proceeded with the takeover.

60%

of the respondents in our study are involved in one or more initiatives such as clinical networks, information sharing, joint treatment or diagnostic centres, new shared assets and joint construction of new facilities.

A key reason behind their move was the opportunity to work together to reorganise Acute and complex care in the Rijnmond region of Holland, which would ultimately improve quality and reduce costs.



Thinking **beyond**

Sir David Dalton, author of the Dalton Review, spoke to KPMG about the pros and cons of different potential models to deliver better care at lower cost, and how to overcome obstacles to change.

This review supports NHS England's intent to get NHS Providers to think beyond their existing boundaries, so that they can reliably deliver high quality services. NHS providers should be clear on the models of care they wish to create; the design principles they wish to pursue; and then determine the governance arrangements to deliver the change. The future sustainability of our NHS requires greater vertical integration between primary, social and secondary care and greater horizontal integration between hospitals. NHS providers need to create new strategic plans to organise the delivery of this change.


Most healthcare organisations in other countries have an enterprise strategy, and a mindset, for change, growth and development, but this is lacking in the NHS; hence the struggle to collaborate effectively. Across Europe and beyond, in contrast, larger healthcare groups place a greater emphasis upon strategic planning, with most managers located centrally in a corporate HQ, setting policy for the group and for each operating entity.

These groups are also characterised by standardisation, initially of back office functions, but increasingly covering procurement, care pathways, and innovation improvement methodology, enabling new technology and devices to be deployed, at scale, across different sites, to improve care quality and bring service reliability and significant efficiencies. There is a relentless drive for high reliability, to minimise operational variability. Regulations are less onerous, providing greater freedom to set their own standards, whereas in the NHS, hospitals must conform to government-imposed targets.

In the UK, it is assumed that staff will contribute to the Board's strategy and values, yet there are rarely formal processes for making this happen. European hospital groups are more likely to adopt recognition and reward programmes, to align performance and behaviour with organisational goals, and to make clinicians and staff fully accountable.

Towards more effective collaboration

Collaboration should be viewed in terms of what's best for the patient, rather than its impact upon organisational or individual status. Too many hospital leaders see collaborative working, partnerships and mergers as either a failure to offer a full range of services, or an opportunity to extend their power base. Often they are inclined to preserve their organisation rather than to find alternative value-adding solutions. Hospitals must also break out of the outmoded 'single hospital' mindset, where a single organisation is expected to provide every service from one site. Currently, not a single UK hospital meets the Royal College of Surgeons standards for emergency surgery – something that can only happen through collaboration, to achieve a sufficient concentration of talent.



Joint ventures of three-to-four hospitals can move us in that direction, although I appreciate the cultural challenges in bringing together institutions with hundreds of years of heritage – and clinicians whose entire careers are tied to one hospital. By pooling their governance and creating single-shared clinical services to serve wider geographic populations, Trusts can share risks and benefits. This is something that is successfully achieved with incineration and laundry contracts, and now needs to be extended to clinical and back office services.

Staff should be supported to give of their best. Incentives are an essential part of what I call ‘systems of consequence’ that reward excellence and intervene when an individual is not contributing to the goals and values of the organisation. Better performers would be rewarded and promoted, and worse ones, who are unable to improve, would be redeployed.

The way in which NHS hospitals are funded makes it hard to increase prices for good service. Therefore, at an organisational level, there should be alternative ways to earn revenue, such as opportunities to develop and support other hospitals as part of a wider, connected group.

It is not right that we should tolerate the extent of variation in either quality or financial viability of our NHS organisations. The Care Quality Commission and regulators can identify those organisations in persistent difficulty; we can implore and should support these organisations to improve but, ultimately, you cannot force organisations to change.

Where improvement cannot be convincingly demonstrated, then, for the sake of providing high standards of care, those organisations who can demonstrate a track record of high performance should be encouraged to manage the failing organisation

through a long-term management contract. This would be a quicker transactional solution than a merger, which would require the transfer of staff and assets to new ownership. The top 30-40 hospitals could receive a kite mark or equivalent, and get involved in managing other organisations through long-term management contracts. Ideally, high performing NHS providers should have ‘earned autonomy’ and be free to set their own branded standards and benchmarks.

Leaders of our NHS organisations must now enjoin their talent and capability with the opportunities that are presented, so that they can design vibrant, high quality and sustainable models of care. New ambitions and a social entrepreneurial flair should create the governance and organisational forms to enable the delivery of such models. These are exciting times.



Standardisation will allow for more effective NHS collaboration

Beccy Fenton, Partner, KPMG in the UK

Entrepreneurial culture is a valuable driver of clinical innovation in the NHS. This more autonomous approach also permeates the management of NHS institutions, and runs counter to the idea of standardisation that gives hospital chains, such as those in India and France, far greater efficiency.

Hospitals tend to rely on capable individuals running a tight ship. However, these individuals often end up firefighting daily problems, partly because standard ways of working aren't embedded.

It's simply not possible for good managers or clinical leaders to replicate their activity across additional sites. The lack of standardisation and codification means that they have to inject a significant amount of personal effort into running things. Staff end up spreading themselves too thinly and performance is compromised.

I'd argue that the adoption of 'Lean' continuous improvement processes and tools, which require a high degree of standardisation, would enable the NHS to codify good practice, improve the quality and productivity of processes and be run in a much more effective way.

In addition to standardisation, another of the founding principles of 'Lean' is that of front-line empowerment. So you're initially skilling up people to operate within standards.

If those standards aren't achieving the best results for patients or staff, or value for money, then the staff will be skilled and empowered to improve them. There's a systematic way of making improvements that can still support the drive for innovation. So I think you can achieve a balance between innovation and standardisation, as in the airline industry.

Implementing these changes within the NHS would require a total overhaul of the way it currently operates. It will also need buy-in and belief from leadership.

None of this is straightforward, and it will require further research and investment at a national level, possibly being trialled in some high-performing organisations that have already started to head in this direction. The adoption of a standardised, lean, continuous improvement methodology would enable the NHS to deliver much greater value for money, improved quality and higher staff morale. Equally importantly, it would provide a solid foundation for collaboration, ensuring that all parties adopt a common approach, and therefore easing the path to integration.



“Most healthcare organisations in other countries have an enterprise strategy, and a mindset, for change, growth and development, but this is lacking in the NHS.”

Sir David Dalton, CEO, Salford Royal NHS Foundation Trust

Other examples of collaboration from around the world

Hospital chains/groups

Helios

Helios is a well-known German group with 110 hospitals across the country, that has grown quickly through acquisition. It provides clinical services across the full spectrum of secondary and tertiary care, and is characterised by a centralised management team supporting regions as well as individual facilities. One of its strengths is a standardised quality management system applied rigorously to every hospital, to continuously measure and improve performance.

Reasons for success

Following an M&A, Helios immediately integrates the acquired hospital(s) into its quality management system, regularly measuring and benchmarking their performance using a wide array of quality and outcome indicators. Any ‘sub-par’ results trigger a peer review, with a view to improving treatment processes. This level of discipline has enabled Helios to reduce in-hospital mortality in the hospitals that it purchased⁵.

Ramsay Healthcare

Australia’s largest private hospital group, Ramsay Healthcare, has network of 38 Acute hospitals and day procedure centres, providing a comprehensive range of clinical specialties to private and self-insured patients. In 2007, it acquired the 22 UK private hospitals of Capio, enabling Ramsay to expand beyond, and reduce its dependence on, its own crowded domestic market. By quickly integrating the group, and applying its well-proven management principles to a market with similar dynamics to Australia, the new hospitals achieved a significant and sustained increase in profitability and market share over the following years.

Reasons for the acquisition

Ramsay successfully tapped the potential of dynamic nature of the UK hospital market. According to Pat Grier, Ramsay chief executive: “There is a huge opportunity for a well-run national group of hospitals to take advantage of this shift to the private sector.”⁶

Franchise

Premier Healthcare

This US provider, while describing itself as an alliance, has many of the hallmarks of a franchise. It is a membership organisation dominated by not-for-profit hospitals. Not only does it carry out centralised procurement for its members, but it also records best practices from across the network and develops these into care delivery standards across the alliance, to help reduce variation and improve quality.

Reasons for success

The hospital system follows a physician-led multi-specialty model. To ensure the effectiveness of its alliance and multi-site provider network, the hospital adopted electronic health records. Thanks to healthcare IT that supported its care model and quality improvement processes, Premier received recognition as an Accountable Care Organization in 2013⁷.

⁵ Hospital chains: a recipe for success? The Kings Fund blog, 27 February 2014.

⁶ Ramsay Health Care buys UK hospitals, Financial Times, 7 September 2007.

⁷ Wesley Ratliff and Premier Healthcare Use Health IT to Build an Accountable Care Organization, healthIT.gov, accessed 29 January 2015.

“In some cases, the acquiring leadership have been very critical of the Trust being acquired. This approach can be challenging for staff and clinicians and sets a poor foundation for the integration plan of the future organisation.”

Anne Gibbs, former Deputy CEO, West Middlesex University Hospital NHS Trust

72%

think existing hospital
business models are
sustainable **BUT**

98%

expect moderate to major
change to their health
systems

Source: KPMG pre-conference survey London 2014

Children’s Hospitals of Philadelphia (CHOP)

This US group has been expanding its reach to deliver integrated care through franchises. For its 11 community hospital partnerships, paediatric in-patient units are staffed by CHOP physicians and specially trained paediatric nurses.

Reasons for success

CHOP created highly targeted development strategies for each local, super-regional, national and international market, and utilised a regional physician network, satellite facilities and partnerships to increase its reach. The hospital chain also set-up referral networks for cardiac, cancer and foetal care.

Joint venture

Medtronic

In 2013 US Medical technology giant Medtronic announced a joint venture with Apollo Hospitals in India, to market a haemodialysis system that increases hope for the country’s estimated 75 million people suffering from chronic kidney disease. Medtronic is the main developer of the system, with Apollo providing clinical insights that can further development efforts.

In a win-win collaboration, Medtronic receives access to a huge market, while Apollo can extend affordable treatment across its nationwide network.

Reasons for potential future success

In providing low cost dialysis treatment in India, the alliance is exporting a well-proven system, using a low-cost, portable approach that doesn’t rely heavily on infrastructure, which suits a large, low-income country like India⁸.

⁸ Medtronic Enters Dialysis With Apollo Venture in India, Bloomberg, 9 October 2013.



Creating the right **conditions** for collaboration

Mark Hackett, CEO, University Hospitals of North Midlands NHS Trust, led the 2014 merger between University Hospital of North Staffordshire and Mid Staffordshire NHS Foundation Trust.

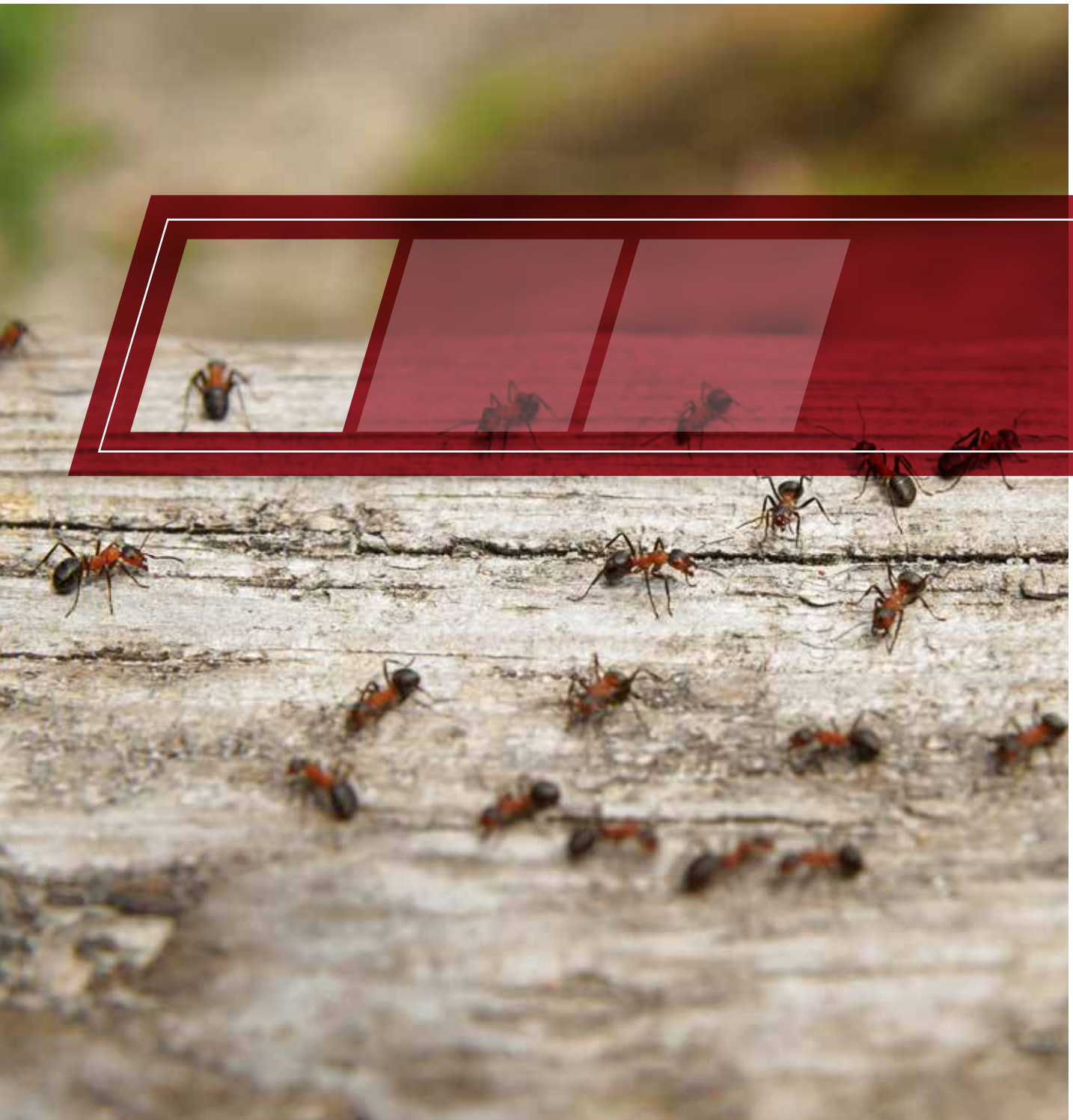
You need time to reap the quality and financial rewards; benefits realisation is not a quick fix but a long haul. When taking on a troubled Trust, transaction costs are inevitably higher and the main regulating body, the Trust Special Administrator (TSA), should clarify upfront the available resources. Our initial experience of mergers was not entirely positive, with unrealistic expectations that pushed up costs. It felt like Alice in Wonderland, where the Queen of Hearts changed the rules every five minutes! We experienced too much interference from external bodies, so the acquiring organisation needs the responsibility to meet its goals within a defined budget, and be fully accountable to the TSA, with a clear governance structure.

In retrospect, I would not repeat the Stafford merger, and would opt for looser strategic alliances. Our partnership with Mid Cheshire Hospitals NHS Foundation Trust, for example, brings together certain clinical services under a memorandum of understanding, enabling each Trust to remain independent. We can support Mid Cheshire with more complex local work that they would otherwise be unable to provide at low volumes. Some of their services are being closed and moved to North Midlands, some are going in the opposite direction, with associated inter-provider agreements.

The service model, commercial framework, goals and values are based not on contracts, but on trust. We've also involved commissioners in discussions from the outset, to demonstrate how the alliance gives better service to patients.

The commissioners are in favour of the partnership, as it solves many local access issues. Such partnerships transcend individual leaders, becoming symbiotic relationships, like those between teaching hospitals and universities. In some cases the contract actually gets in the way of doing the right thing.

Most collaborations could be achieved through joint ventures involving public and private organisations, with special purpose vehicles (SPVs) playing a role. In the future there are likely to be loose affiliations between hospitals, covering procurement, internal audit, or particular clinical services. In time this could progress to an alliance agreement, with joint objectives that deliver mutual benefits. Joint ventures inevitably take the relationship to another level, requiring a long-term agreement, with a contract to cover the increased risk arising from capital expenditure.



“Without standardisation and codification, it’s simply not possible for good managers or clinical leaders to replicate their activity across additional sites.”

Beccy Fenton, Partner, KPMG in the UK



Collaboration can bring scale and flexibility, to help utilise facilities more efficiently and cost-effectively.

03 Funding collaboration

Demand for healthcare is rising incessantly, and expenditure is unable to keep pace. Between 2009 and 2012, while government healthcare expenditure kept track with inflation, the proportion of GDP spent on health in the UK fell by half a percent, and in the two years up to 2011 (the latest figures available), health spend per capita fell in real terms by almost two percent annually¹.

At the same time, hospital funding is becoming more unpredictable, due to increased competition, with commissioners able to choose between a wider range of providers, including primary/community based care. The open market is also driving prices down, further threatening turnover.

With funding under severe pressure, Trusts' ability to invest in physical or human resources is severely limited, and some are struggling to even maintain day-to-day running costs including salaries.

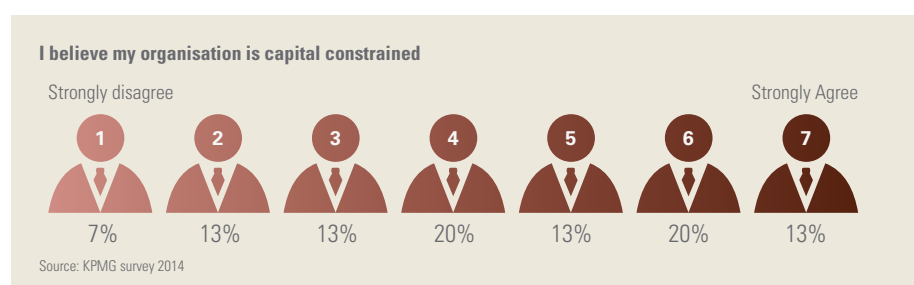
NHS Trusts in England ran up a combined deficit of £467 million in the first quarter of 2014-2015, and in 2014 the NHS England's chief executive, Simon Stevens, warned of a £30 billion annual deficit by 2020, with the health service needing an extra £8 billion a year.

According to a 2014 BBC report, some Trusts are still counting on large government bailouts, although such interim support, which totalled more than £500 million to 31 trusts in 2013, could run out or at least be rationed².

Consequently it is little surprise that 46 percent of the Trust leaders taking part in the study feel that their organisation is capital constrained, and 39 percent indicate that administration is 'possible' within the next three years.

...health spend per capital fell in real terms by almost

2% annually



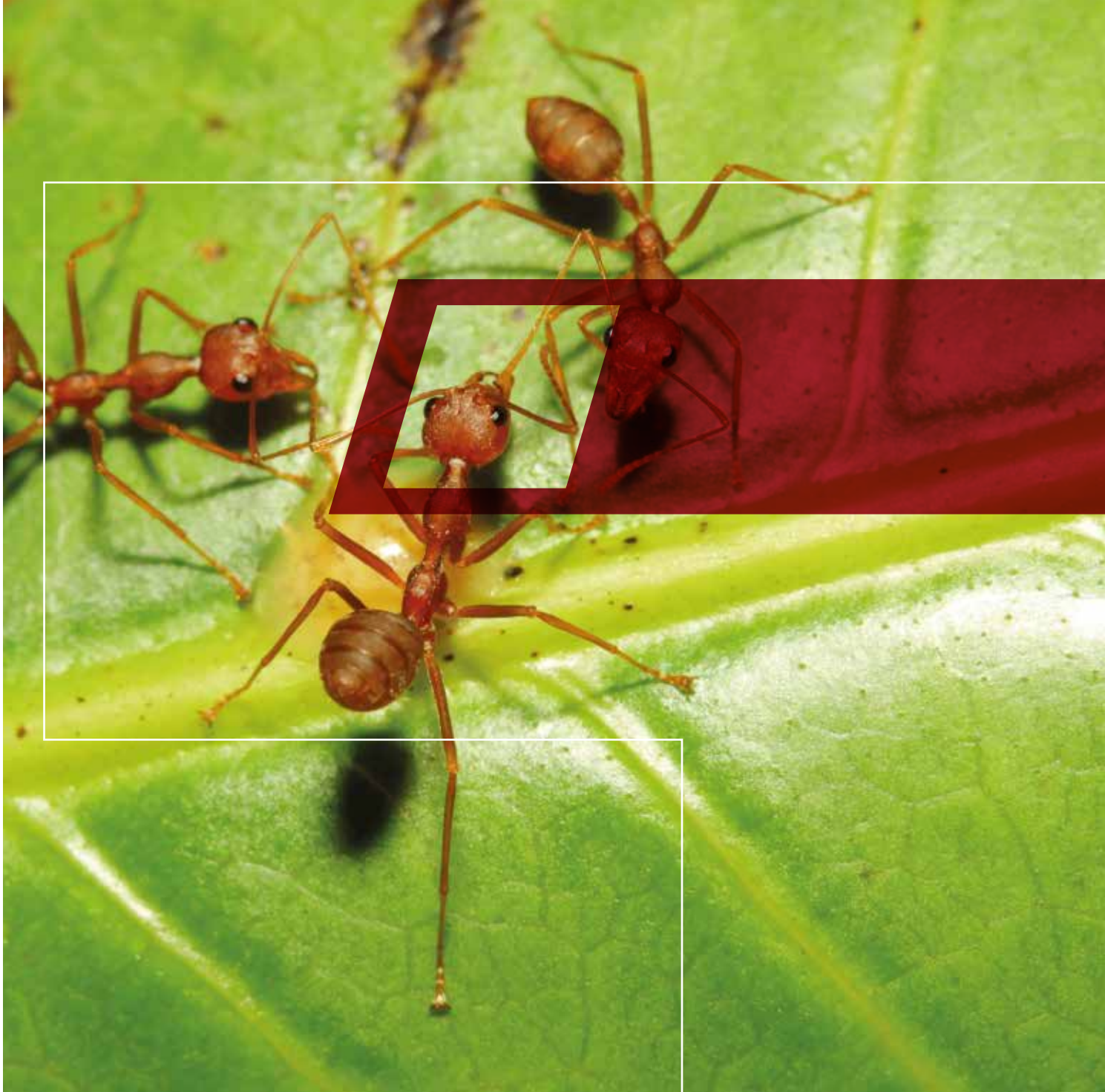
The *NHS Five Year Forward View*³, urges a shift to care in the community, which could further reduce demand for Acute Trusts' services, and render parts of their estates redundant. Equally, moving care out of hospitals will also require investment in new, local infrastructure to support this new model of care.

The public purse remains the main source of funding for capital expenditure on UK hospitals, through a process of capital allocation, provided as either debt or equity. Public dividend capital (PDC) is the most common form of long-term government finance for NHS Trusts, enabling them to purchase their assets, with the Department of Health retaining an appropriate equity interest.

¹ OECD Health Statistics 2013, <http://dx.doi.org/10.1787/health-data-en>.

² NHS trusts borrowing heavily from state bailout fund, BBC, 30 October 2014.

³ NHS Five Year Forward View, October 2014.



The Integration Transformation Fund (ITF) is a single pooled annual budget of several billion pounds, available for health and social care services attempting to work more closely together in local areas.

As public money gets ever scarcer, capital investment plans are coming under intense scrutiny. The approval process for transactions has gone from being slow and complex to tortuous and glacial, with three separate business case stages often requiring the approval of six layers of Boards/government. In addition, increasingly tight capital budget limits, combined with stringent accounting rules serve to limit the availability of public capital.

NHS investment, therefore, almost always relies on some form of collaboration with the private sector, often involving private finance. Public-private partnerships (PPPs), primarily in the form of a Private Finance Initiative (PFI) have enjoyed considerable popularity in the past couple of decades, and the recovery in market liquidity is once again raising the attractiveness of private sector capital.

There is a lot of logic in these arrangements, as a Trust's core focus should always be delivering excellent clinical services, while private sector organisations, such as construction contractors and facilities management

companies, often have the skills and experience in building and managing large estates, as well as better access to capital.

In traditional PPPs, private investors typically build and operate hospitals, taking the full construction and asset performance risk as part of a 25-30-year contract. The downside of such an arrangement is that Trusts have little or no say in how the building is built and run, and any modifications can be complex and costly. Increasing levels of criticism in and outside the press has also made Trust management generally hesitant to pursue the PPP model, at least in the form of PFI or PF2.



Where the NHS hospital already owns its buildings, the private partner sometimes takes over an ownership role in return for providing capital to develop ...

Innovative financing models to bridge the funding gap

More recently, hospitals are starting to lease both existing and new facilities that are funded by banks, pension funds, equity investors and/or other financial institutions. In the case of a new build, this transfers less risk to the private party (a degree of construction risk but little or no asset performance risk), but gives the Trust more influence over design and build, and greater flexibility to make changes. In some cases, the NHS achieves co-ownership of the facility under a joint venture agreement.

Where the NHS hospital already owns its buildings, the private partner sometimes takes over an ownership role in return for providing capital to develop and/or re-use this facility, or indeed other parts of the estate that require further investment.

NHS Trusts enjoy a guarantee from the Secretary of State as payer of last resort. NHS Foundation Trusts, on the other hand, have no explicit guarantee, although there is a general expectation that the Government will back their debts, something which is implicit in the legislation but probably necessary in any event, for financial and political expedience. PFI deals carry an explicit assurance known as a Deed of Safeguard. These various mechanisms give lenders a high degree of comfort that obligations are likely to be paid, which, crucially, can help to reduce the cost of private capital.

Maximising the benefits of collaboration

Although only 17 percent of respondents claim to be collaborating primarily to improve financial sustainability, a merger or joint venture can open up opportunities to reassess the estate, and help raise funds to invest in new models based around community care.

The majority of NHS mergers to date have been centrally funded, but many have subsequently suffered from a lack of capital investment in the new organisation. In order to improve the merged entities, Trusts need to reorganise the way they deliver care, sell, lease and/or upgrade different assets and invest in new, community-based infrastructure and services. These advances can help consolidate Acute provision and reduce the number of beds in those Acute hospitals as part of a shift towards primary/community care, and away from large, expensive, Acute hospitals.

One way to release cash is to work with a third party through a strategic estates partnership (SEP), bringing in a specialist estates manager (usually a private sector organisation) to take responsibility for planning and managing the entire estate. Usually, these organisations are empowered to propose new estate solutions and can offer to source capital and carry out essential development work as part of the joint venture.

Yeovil District Hospital NHS Foundation Trust has entered into a strategic estate partnership in a bid to move frail elderly patients from Acute facilities into social care, with plans to create a nearby health campus that includes a care home and health facilities such as gyms. The Trust would be unable to fund such a move without private finance to build and operate the new buildings.



Global healthcare funding challenges



Netherlands

Dutch banks' appetites for funding healthcare capital have decreased amid fears that hospitals will be unable to repay their investments. Selective procurement from health insurers, competition between providers, and falling demand for secondary care has impacted revenues. Since 2012, Acute Trust turnover has decreased, and 80 percent of the leaders surveyed believe that their organisations' turnover will become more volatile. Hospitals, once regarded as a relatively safe investment, now have a similar risk profile to commercial organisations.

Half of the Trusts in the study cite financial uncertainty as a driver for collaboration, notably to enlarge their catchment areas by partnering with a neighbouring Trust. Some have chosen specialisation as a means of differentiation – a strategy favoured by health insurers and capital providers – in order to achieve greater efficiencies and increase quality of care. However, specialisation reduces volume of turnover, threatening their ability to repay interest and contractual obligations.



With Trusts now seeking capital on the open market (rather than from Government), interest rates are likely to be higher and credit margins lower, raising the cost of capital. This will necessitate tariffs and/or reduced operating costs, and business plans require support and endorsement from health insurers, in order to satisfy traditional and new investors. Acute Trusts are currently financed by a small circle of banks, and should start to look further afield for funding, while simultaneously clarifying their service offerings and underlying business models.

Portugal

Although the majority of funding comes from government, the private sector has assumed a more important role as part of a programme of hospital PPPs. Interestingly, almost a third of healthcare expenses are paid privately, which is above average for most OECD countries. As some of the deals encompass clinical services, lenders take some of the operational risk in addition to the design, construction, maintenance and finance risks. There is no direct guarantee except for government default cases, but the government acts as a guarantor of last resort.

The financial and sovereign debt crisis has brought tough austerity measures and a stop on future investments. Despite PPP projects potentially providing good value, these deals attract considerable scrutiny – partly because of a lack of flexibility to reduce payments during hard times – and consequently are currently on ice.





Canada

The tightening of government budgets has held back growth of hospital capital budgets, and, in order to satisfy capacity for an aging population, PPP has taken a foothold in Canada's public healthcare system. Most of the private sector money has flowed into longer-term, capital maintenance and 'soft' facilities maintenance services such as grounds maintenance, with delivery of hospital programming and services remaining in the public domain.

Financing for PPP projects comes from a wide range of entities. On the debt side, almost all of the large Canadian banks participate, along with several life insurance companies, while equity investors include major asset management, global construction and infrastructure groups.

The ultimate funding for hospitals is typically provided by provincial government, through milestone payments during the construction period, and availability payments during operations. Fixed price contracts are the norm, with the private sector taking on design and construction risk, along with lifecycle risks, to maintain the facility to pre-defined specifications and meet all handback requirements at the end of the project term. There is no revenue risk, as the public sector manages the operations.



Australia

Australia has also embraced PPPs, with equity capital funding coming from stock market listed organisations, specialist infrastructure fund managers, private equity fund managers (typically for smaller hospital facilities/groups), selected not-for-profit healthcare groups (often faith based), and large superannuation funds. Banks are the main source of debt funding for hospital operators and projects, with the four major Australian trading banks retaining a high degree of appetite for healthcare.

Lenders take on all the risks associated with property development, namely pre-operation development risk (e.g. for planning and approvals) and construction risk, and at the operational stage will assume demand risk, operational risk and HR risks such as health and safety. In the case of PPP and PFI transactions, banks are prepared to take operational risk.



When it comes to financing private hospitals, banks tend to prefer brownfield expansion projects. For greenfield initiatives, they would seek a strong counterparty to underwrite the volume risk, via a long-term lease.

Any hospital projects in Australia are impacted by difficulty in finding appropriate sites, a lengthy planning and approvals process and high development costs. In a consolidated private hospital market, developers need to negotiate competitive funding arrangements with private health funds.



“Alone we can do so little; together we can do so much”

Helen Keller



The system needs completely new ways of delivering care. That is going to require collaboration between the different organisations...

04 Conclusion

The case for more and other forms of collaboration Unprecedented challenges for the NHS

The NHS in England is currently facing unprecedented challenges. Certain parts of the system are under severe pressure. An example is the way that Acute hospitals struggle to keep up with the rising demand. As a result, most of the A&E departments across the UK were unable to meet the four hour waiting targets for most of December 2014 and January 2015. The main reasons for the system being under severe pressure are:

- Aging population resulting in increasing and changing demand
- A growing population resulting in increasing demand
- Lifestyle factors resulting in increasing and changing demand
- Changing expectations from the public
- Shortage of skilled staff like nurses and consultants to meet demand
- Rising costs of health care resulting in pressure on budgets
- As discussed in this year's featured topic, the challenge of insufficient capital funding is now looming large and arises from a mix of macroeconomic, structural and fiscal factors.

This is a long list of really significant challenges and it stands to reason that incremental change won't be enough to overcome them. The system needs completely new ways of delivering care. That is going to require collaboration between the different organisations in the system. There is considerable consensus on the best way forward, namely:

- A shift towards primary and community care
- Greater integration between all parts of the care network. Acute Trusts and Foundation Trusts working more proactively with community, mental health and social care services.

NHS organisations will not be able to resolve these unparalleled challenges in isolation. Collaboration plays a vital role in achieving such a transformation, to improve quality and affordability of care. As this paper shows, a majority of Trusts are already engaged in collaboration and embrace new forms, something proposed in both the Dalton Review and the Five Year Forward view. Our review also highlights some of the frustrations experienced along the way, and it is our hope that future collaborations can learn from these lessons.

Checklist lessons learned



Design the solution to match the problem



Prioritise sustainability over short-term financial aims



Ensure that both parties have something to gain



It's about the patient



Engage and communicate with staff



Don't under estimate the importance of culture



Standardise and codify good practice



Align payment and incentives



Measures such as access times, readmissions, length of stay and patient flow are relevant, along with longer-term metrics including mortality rates, patient experience, patient reported outcome measures, and staff morale.

Eight lessons learned to facilitate successful collaboration

1. Design the solution to match the problem

Form follows function, so be sure that your choice of collaboration addresses not just organisational and operational efficiency, but the longer-term needs of the population you choose to care for. On an organisational level leaders should consider the following things when choosing the form of collaboration:

- The type of organisation (patterns from the past and current situation),
- The purpose and strategy of the organisation (plans for the future),
- The whole health economy that the organisation is part of.

A specialist provider in London, for example, might choose a network or franchise model to enhance specialist services, along the lines of Moorfields Eye Hospital.

A district general hospital in south east England, on the other hand may elect to collaborate more closely with its community – perhaps by taking a lead provider role in an integrated care model – in order to improve patient experience and outcomes.

2. Prioritise sustainability over short-term financial aims

It takes an incredible amount of time and effort to make a collaboration succeed, so Trusts, commissioners and regulators should take a long-term perspective, and give leadership time to right past wrongs, make appropriate changes and achieve desired results. The initial case for change should define benefits (in terms of quality of care and wider systemic value), which would then be tracked.

3. Ensure that both parties have something to gain...

Each of the hospitals or other institutions entering a collaboration is naturally concerned primarily about its own specific problems. Formal ties such as contracts and joint performance targets can create a mutual interdependency that should get all parties working together towards a common goal.

4. ...but remember that it's not about you, it's about the patient

Collaborations are not designed to widen one chief executive's power base. Nor should the subject of a takeover, or a smaller party in a joint venture, feel concerned about its status in the new organisational model. The sole reason for the NHS's existence is to benefit the patient. Everyone involved should aim to ensure that whichever form of collaboration is chosen maximises value for the patient.



Clinicians and other staff want to understand the rationale behind the collaboration and the impact it will have on their daily work.

5. Engage and communicate with staff

Clinicians and other staff want to understand the rationale behind the collaboration and the impact it will have on their daily work. Clinicians can have a key role in planning the integration and the redesign of services, achieve the right mix of capacity and capabilities across the system or to ensure that staff will want to work across organisational borders. Through clear communications, and by involving people in the decisions that affect them, it is possible to keep staff engaged and enthused.

6. Don't underestimate the importance of culture

Before attempting to collaborate, each party needs to get a clear view on the other's similarities and differences in values, leadership style, decision making processes and accountability regimes, which can be extensive and potentially divisive. Cultural assessments can expose potential risks. It is unrealistic to expect to instantly build a homogenous culture, but it is possible to create some shared values that bring you closer together.

7. Standardise and codify good practice

NHS organisations can operate in very different ways, often based around the management styles of individual leaders. Such random styles are impossible to replicate, as they are based around people not processes. Standardisation and codification of the way things are done can significantly increase the success rate of collaboration. Particularly the types of collaboration impacting on the autonomy of both partners. It will make good practice more easily transferable between collaborating organisations. It can provide a solid foundation for collaboration, ensuring that all parties adopted a common approach, and therefore easing the path to integration.

8. Align payment and incentives

Currently Acute Trusts and Foundation Trusts are paid according to how many patients are in their beds. We need a model that encourages collaboration across tiers of care such as primary and community care. Collaboration should result in Acute Trusts and Foundation Trusts working more proactively with community, mental health and social care services. This requires a payment system and incentives that focuses on what truly adds value for patients.



Methodology

The observations and conclusions in this publication are partly based on publically available sources, and experiences in our Audit, Tax and Advisory practice. In addition, a survey was conducted amongst CEOs of Acute Trusts and Foundation Trusts in England. Seventeen CEOs have completed the survey. Furthermore, interviews were held with four eminent leaders in healthcare.

We are very thankful for their valuable contributions. Due to their cooperation and willingness, we were able to make this document. In anticipation of the next report, we again hope to receive your cooperation and valuable insights.

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KPMG Survey 2014

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Interviews

Interview participants:

Anne Gibbs, former Deputy CEO, West Middlesex University Hospital NHS Trust

Nigel Edwards, Chief Executive, the Nuffield Foundation

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