KPMG

# Take me to your leader

## Hospital collaboration in the NHS

# Table of Contents

| | |
|---|---|
| Take me to your leader: part one – Beccy Fenton | **2** |
| Collaboration by the numbers | **3** |
| A few good men and women | **4** |
| Lighting the blue touch paper | **5** |
| What's next on the STP "to do" list? | **7** |
| Just make it happen | **8** |
| Something's come between us | **10** |
| Take me to your leader: part two – Matthew Custance | **13** |
| Case study one | **16** |
| When the eyes of the (healthcare) world turn to Manchester | **18** |
| Choose your vehicle | **21** |
| There is another way | **23** |
| Case study two | **26** |
| When the STP met the GP | **28** |
| Summary | **31** |


# Take me to your leader

## A story of collaboration in UK healthcare

**Part one by Beccy Fenton**

Welcome to the latest study by KPMG into collaboration in UK healthcare. Last year we focused on exposing some of the myths behind healthcare collaboration, concentrating on the facts and issues shaping the collaboration landscape identified from our survey with NHS CEOs.

This year, we have seen a quantum shift in the need for collaboration born out of the arrival of the Sustainability and Transformation Plans (STPs) and the new two year planning guidance. A recent quote from the HSJ nicely sums up the current mood in the NHS – "NHS told to stick together or rather than hang separately!"

So whether society like it or not, collaboration is now well and truly on the map and we wanted to know more about what makes healthcare collaboration successful and what prevents it.

To find out, we asked the views of a select group of 25 NHS CEOs in April 2016. A summary of our findings are presented in this report, alongside the personal views of KPMG specialists and several prominent industry figures including Sir Robert Naylor, Chief Executive at University London College Hospitals; Nigel Edwards, Chief Executive at Nuffield Trust; Sarah Pickup, Deputy Chief Executive at Local Government Association; Samantha Jones, Director of New Care Models; Jon Rouse, Chief Officer at Greater Manchester Health & Social Care Partnership; Lesley Watts, Chief Executive at Chelsea and Westminster Hospital NHS Foundation Trust and Rob Vickers, Chief Executive Officer at Digital Life Sciences. I would like to thank all of our interviewees for their time and their insights.

Several key themes emerged including significant support for the concept and benefits of collaboration and a pragmatic understanding of the difficulties of making it a reality. No one is suggesting that a truly collaborative, integrated health and care system is about to emerge overnight.

Most important is establishing the tone. The rationale for collaboration needs to be about improving the health and quality of care for the local population in a way that is affordable – organisations will have to put their local population's needs before their individual needs to be truly collaborative.

Leadership is vital for this. In fact, we agree with many of our interviewees that having strong collaborative leadership skills will be the single most critical success factor to integrate systems and meet the objective of STPs. This is a big change for NHS leaders who have historically worked in a more competitive environment.

System leaders will need to work together differently; creating open, transparent and collaborative relationships that put the population first. Only by creating and maintaining good working relationships can different organisations engender the trust needed to make collaboration work. Research shows that for this to happen successfully there needs to be investment in systemic leadership skills. These leaders will need to be able to show that they own the system plans and are prepared to be held accountable for systemic transformation.

Elsewhere in the report, we touch upon other important issues such as the learning from New York State's healthcare transformation programme which is creating provider collaborations and new payment mechanisms to drive up quality and reduce cost, the devolution agenda and how healthcare transformation connects with the wider public services reform, and the role that mergers and acquisitions still have to play in the future of the NHS. All these points are crucial for collaboration to thrive.

I hope this report gives you food for thought on the benefits of collaboration and examples of how to overcome some of the barriers. I would be delighted to discuss these points with you to help make your collaborations a success.

# Collaboration by the numbers

For the purpose of this report, KPMG surveyed a small number of senior healthcare executives[1] in the UK about collaboration. From that research, a few headline statistics stood out for me, namely that:

**68%**

**of respondents felt that the future is all about collaboration and that competition is dead;**

**60%**

**said that there are too few good leaders in the NHS; and**

**64%**

**said that the single biggest barrier to effective collaboration between organisations is individual bias and politics.**

Just over two-thirds of our respondents believe the future of healthcare lies in collaboration. Thats why we're still writing and talking about this topic. Collaboration is, justifiably, the name of the game right now. For that reason, some may have expected that 68 percent figure to have been rather higher. Regardless, it's a good start for now.

However, let's have a look at the second half of that sentence. Competition isn't dead, nor should it be allowed to die, nor should it be seen as a bad thing. Competition should be welcomed if it helps drive up clinical standards. Sadly, I believe that, in some instances, it's currently being used as an excuse or a blunt weapon to prevent collaboration or the implementation of necessary improvements to patient care.

Ten years ago, competition was welcomed as a tool with which to make organisations more entrepreneurial and more efficient. Now, it is seen as a blocker to change; its reputation has been tarnished. You can therefore understand why parts of the system are pushing back against competition in favour of collaboration.

Some caution is required here though. People may not like the legislation, fearing it goes too far perhaps, but the Health and Social Care Act standards for competition still currently need to be considered when embarking on collaboration. The ways things currently stand, this may delay STPs doing what they want to do.

1 In total, a select group of 25 chief executives, acting chief executives and interim chief executives were interviewed in the spring of 2016, representing NHS Trusts and Foundation Trusts across England.

# A few good men and women

The point about there being too few good leaders stirs up an interesting debate. Elsewhere in this report, you'll see it argued that there are enough good leaders but that they simply need further training and development to meet the new-found requirements of collaborative healthcare system leadership.

However 60 percent of survey participants said that there are too few good leaders in the NHS. Therefore we urgently need to focus on why the pool of talented leaders may be so small.

That argument suggests that NHS culture, which to date has been much more about accountability of short term performance than about values and excellence, creates a difficult environment within which to nurture and develop inspirational collaborative leaders.

As for the 64 percent who worried about individual bias and politics getting in the way of collaboration, I interpret this statistic as a reminder of how the current structures make it very difficult for people to adopt a perspective other than that of their own organisation, even when they would rather behave more systemically.

Time and time again, what matters most to us is what is closest to us. That's not just a healthcare issue; it applies in a whole host of industries, professional services included. It is remarkable how often we can be blind-sided by what another organisation – or even another department within our own organisation – is doing.

Completely unaware of their struggles and successes, their initiatives and processes, the scope for collaboration can be diminished.

All of which brings me back to leadership. I would suggest that being able to rise above the constraints of bias and politics is the mark of a strong leader in any environment.

Within the context of the new STP footprints, which are the current route to transform healthcare in this country, I hope the new system leaders are able to demonstrate exactly that.

# Lighting the blue touch paper

The arrival of the Sustainability and Transformation Plans (STPs) in December 2015 was a game-changer, not just because these plans require systems to come together and agree their transformation plans and blueprints for health and social care integration – but because of the very different breed of leader which they will require in order to be successful.

In fact, I would go as far as to say that system leadership will be the single most critical factor in determining the success of the STPs.

I don't see how the STPs will work without very strong system leaders; leaders who will genuinely be able to prioritise the requirements of the system they lead above the requirements of their own health organisation.

### Challenging

There is no doubt that this will be hugely challenging. An array of potentially conflicting priorities could see leaders being pulled in so many different directions: perverse financial incentives, uncertainty about career progression, as well as concerns over their own organisation's individual performance, long term security and sovereignty will all conspire to make the system leader's job an unenviably tricky balancing act.

There is absolutely no doubt in my mind that the system-led STP approach is the right approach for delivering improvements to the NHS, so long as the programme is seen as the beginning of a journey away from short-term fixing and a move to longer term planning. This is the chance for the NHS to move from being a tactical organisation to a strategic one.

However, if the NHS does not invest in leadership development to help them overcome these conflicting priorities, I fear the chance may be wasted and the STPs could sit on leaders' shelves, gathering dust like many previous NHS initiatives.

While I maintain that leadership is the most critical factor, there are other factors worth bearing in mind which will help determine the success – or otherwise – of the STPs.

### Other concerns

Nigel Edwards, Chief Executive at the Nuffield Trust, is, like me, a supporter of the aims and ambitions of the STPs. Nevertheless, he shared with me several concerns he has for the programme when we spoke earlier in the year:

> ..."I would go as far as to say that system leadership will be the single most critical factor in determining the success of the STPs"

**Behind the Sustainability and Transformation Plans:**

Forty-four geographic STP footprints were announced in 2015, each to be convened by a local leader and backed by national bodies. The health and care organisations within these geographic footprints will work together on initiatives such as investigating new models of care, promoting innovation, integration and more personalised services.

There should also be a greater focus on the well-being of the local population, considering how to prevent the main drivers of ill health such as smoking, obesity, alcohol and a lack of physical activity. The STPs will also be tasked with improving the productivity and efficiency of services and securing maximum value for money on all investments which they make.

## Nigel Edwards, Chief Executive, Nuffield Trust

'It's hard to argue with the concept behind the STPs. After all, the main challenges which they are supposed to address – productivity / efficiency, duplication, acute care activity and fixed costs – have so far proved very difficult for many individual organisations to resolve. Therefore, what other way is there of tackling this?

However, we need to be mindful that perhaps even this system-wide approach may prove insufficient. In any case, we need to not neglect the importance of incremental and more radical improvements within individual organisations.

There is a nagging fear here of how this planning exercise will differ from those which have gone before, if at all. Too often in the past, people simply worked backwards from a prescribed target number (a cost saving or control total), reverse engineering an operational process to conveniently fit. From experience, this can result in a narrative which is disconnected from the numbers.

Fingers crossed that this doesn't happen again and that lessons have been learned. But I wonder whether the 'target number' for the STPs is going to be so mind-bogglingly large (such is the scale of the programme) as to prevent anyone actually figuring out how such a target can be achieved.

**Tick, tock**

The time required to develop and, more importantly, implement these solutions is against us. And I think that available capacity, at both a clinical and managerial level, is a crucial concern here. The clock is ticking and has been for some time already. The STPs are supposed to be an important factor in the delivery of the NHS Five Year Plan. By the time the STPs' first drafts are in, we shall effectively be left with just over three years to go.

The leaders of the STP footprints are in new roles and, in some cases, the geographies are different from those that have previously existed. This means that the powers-that-be will need to see the July assessment of these plans as the first stage in an iterative process. The quality of the thinking and planning may not be up to the required level in such a short space of time.

There are two other points which I think will be important factors in the success (or lack thereof) of the STPs. The first is the availability of people who are skilled in planning projects on this sort of behemoth scale. Such people will likely prove to be few and far between.

The second is how the system will work in practice when individual organisations have their accountabilities really tested. Can an organisation be sufficiently incentivised to give the needs of the system equal, if not greater, weighting than the needs of the organisation? On the face of it, that appears a tricky balance to strike."

**Leadership in context**

Nigel has listed many concerns here and his comment about skilled project leaders being few and far between suggests that he may well have concurred with the 60 percent from earlier who felt there were too few good leaders.

But what is good, strong leadership within the context of an STP going to mean in practice? Well, first up, I believe that the system leaders themselves will need to recalibrate their own thinking. Simply acting as a staunch advocate for, or representative of, their own organisation is not what is required here.

In fact, that would run directly counter to another of their early objectives; to build trust within their newly-formed senior leadership team. Without trust in what the leader is trying to achieve for the benefit of the system, I fear that these leadership teams could quickly become riddled with distrust over whose organisational needs will end up being given primacy.

I would suggest that the best system leaders will demonstrate openness or even vulnerability, acknowledging where mistakes may be made or where their own expertise comes up short. Only by laying every single decision out for challenge and scrutiny will that trust begin to build.

# What's next on the STP "to do" list?

In Nigel's views earlier, we saw the first references to accountability and incentives. I agree that these are two factors which most definitely have a significant role to play in all collaborative activity, not just the STPs.

That's why I would recommend that the STP leaders begin to address – as a matter of some urgency – the perverse financial incentives which can get in the way of securing the right outcome for the patient. How, for example, can acute care and community care collaborate effectively when moving a patient from the former to the latter can directly affect the former's financial viability? Plus, the division between health and social care budgets creates even greater and more complicated perverse financial incentives which we know are adversely affecting the quality of care.

Frustrations like this can – and should – be addressed at a system level, leveraging the power which now resides with the STP footprints. The most recent STP guidance makes it clear that STPs can use their new found freedom to create new payment systems which can align incentives and create the right behaviours.

For example STPs can now 'bid' to create 'system control totals' as an enabler for real transformation.

New models of care and different organisational structures will be required to create system wide governance and enable system leaders to hold people accountable for change. Measuring the performance of a system will require different types of indicators including those measuring population health and well-being, in addition to the quality of care and system wide productivity and efficiency.

Before new governance and financial systems are formalised, the accountability vacuum can only be filled by leaders collaborating and doing the right thing for their local population.

**A new discipline**

Encouragingly, there are a growing number of leaders who recognise that this is a new discipline that requires a new approach. These system leaders understand that effective leadership teams won't be formed overnight and individuals won't slip seamlessly into the requirements of their own role.

For that reason, I would like to see a programme of investment in systemic coaching to develop leaders. I'd also like to see these leaders given an appropriate amount of time to make this a success. As mentioned before, this is a long-term undertaking, not a short-term one.

Another plea to the leaders themselves would be to remind them that form should follow function. New models of care, M&A, chains or other forms of collaboration may well help formalise governance and accountability but they shouldn't be used as a starting point. Establishing exactly what the problem is that the system and its STP are supposed to solve merits extensive and careful consideration from the outset.

All of these points contribute to an increasingly daunting 'to do' list for these system leaders. It is a big ask and a huge opportunity, if the leaders are armed with the right beliefs and appropriate tools and support I am sure they can find a way to get everyone pulling together – putting the needs of the population above the needs of Individual organisations; putting the needs of the many ahead of the needs of the few.

# Just make it happen

Clearly, anyone tasked with delivering a more integrated health and social care service would dearly love to be given the definitive "how to" guide. Unsurprisingly – no such guide exists.

However, what role could – or should – our politicians take in order to provide the guidance which many may crave? No less a figure than Sir Robert Naylor, Chief Executive at University London College Hospitals, told me that if an integrated, more collaborative, health and social care model is to become a reality, it needs more central direction and guidance from government than it is currently receiving.

However, he also suggested that there may be a (somewhat understandable) reluctance to provide too much in the way of top-down direction so relatively soon after Andrew Lansley's reforms which introduced more competition directly into the NHS. He said:

## Sir Robert Naylor, Chief Executive, University London college Hospitals

"Alongside several of my industry peers, I spoke to the incumbent government before their 2010 election defeat, advocating greater collaboration, rather than competition. Much of what we're seeing now echoes the sentiment of that discussion.

Moving away from focusing on discrete episodes of care with individual patients; thinking more holistically about the health status of entire local populations; creating the best patient environment by bringing together all the healthcare agencies who can help the patient to better help themselves – none of these are revolutionary concepts.

How to make this work is where the challenge really lies. Plenty of healthcare chief executives remain solely focused on the success of their own organisation. Clearly, that's absolutely understandable as that is what they are paid to do. However, they should also be responsible for their local healthcare status, not just their own organisation's financial viability. And this is why it's disappointing that the politicians haven't stepped in to provide more direction on how to make this happen.

It's as if they're hoping that the Accountable Care Organisations (ACOs) fit for a modern age – which we all want to see – will simply emerge from the vanguard programmes or the Sustainability and Transformation Plans (STPs). Of this, I believe there is no guarantee.

The Five Year Forward View began to move the NHS in the right direction but a clearer, more defined roadmap is now needed. In the case of the STPs in particular, without that clear direction on what they're supposed to be doing – or how – I think they'll struggle to succeed.

**The right rationale**

Moving away from the politics and into the realities, when the process of stitching together the various healthcare providers begins in earnest, we need to ensure that the rationale is right. That rationale should be centred on improving the local population's healthcare status, not generating greater organisational scale or competitive clout.

Secondly, if a fully integrated healthcare system, led by a single ACO, is to become a reality, the issue of GPs' status as independent contractors within that system needs to be addressed. Typically, there has been little or no appetite for looking at changing the current status quo. However, I sense a greater willingness among GPs to come under the umbrella of a healthcare provider. The demands of running a modern day healthcare business, coupled with rising property prices have seen to that.

And finally, there is the issue of leadership to be addressed. For starters, I don't think it necessarily follows that the acute care leaders should be the default leaders of these ACOs.

Whoever comes in faces a significant challenge in stitching together acute, primary, secondary and community care. We will have to be open-minded about the skills gap which this will expose.

These leaders will need time to learn new skills and to adapt to the requirements of this very different role.

Combine this with the reluctance to provide too much centralised, top-down guidance within the current political environment and it's clear to me that then transition to successful ACOs will not be a rapid process.

Courtesy of Sir Robert, we begin to see some common themes emerging here; leadership, the primacy of the needs of the system and the requirement to be clear on the rationale for any collaboration.

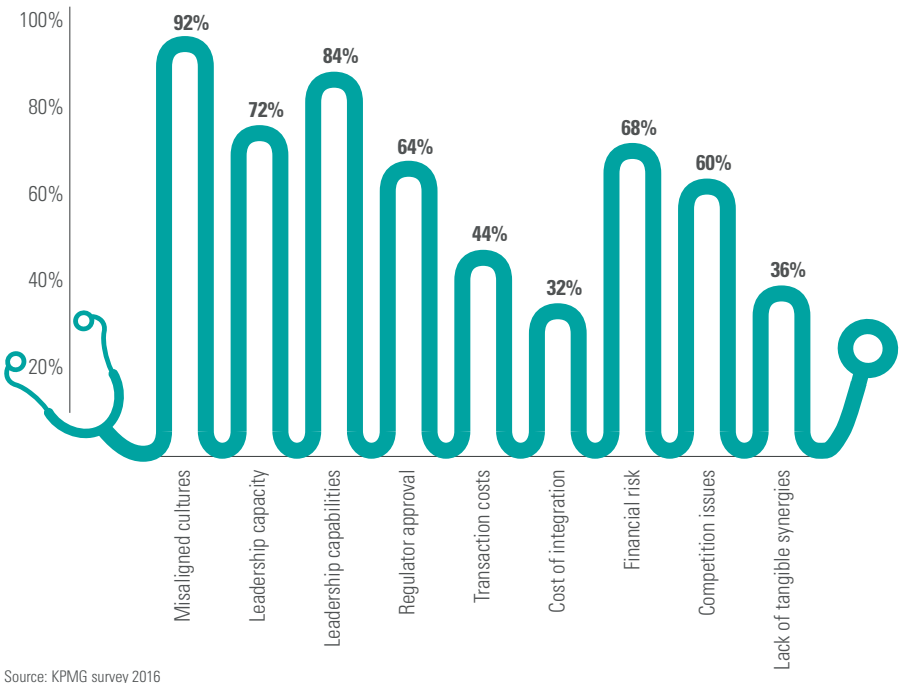
# Something's come between us

For now, let us assume that the rationale for collaboration is clear. We might want more centrally provided direction on how to get there but we broadly know where we're going and what we want to achieve. So what's going to stop us achieving it?

Sarah Pickup, Deputy Chief Executive at the Local Government Association, picked up the baton here, identifying several further barriers which she can imagine getting in the way of effective health and social care collaboration and integration. She told us:

When asked what they perceived to be the biggest barriers to successful collaboration, our survey respondents almost all mentioned misaligned cultures. Leadership capabilities and capacity also proved to be popular picks. Cost was evidently less of a concern however, with transactional costs and the cost of integration both featuring in the bottom three.

Barriers to successful collaboration




Source: KPMG survey 2016

## Sarah Pickup, Deputy Chief Executive, Local Government Association

"Incentives are an obvious barrier; incentives which, while not encouraging bad behaviour, are not exactly conducive to making people adopt different behaviours either. For example, payment by numbers in the acute sector hardly incentivises people to investigate alternative care models which may help control their demand. There is also something to be said about not understanding your partner organisations well enough. Strong, local relationships will be at the heart of integrated care. Yet to create these, we need to circumvent the lack of mutual understanding that can exist as to how each other's organisation works.

Everyone agrees that understanding what the patient wants and needs is crucial to successful healthcare collaboration. However, it is also important to stand in your partner organisations' shoes, to understand what makes them tick and what their "must do" activities are. Those "must do" items can be so different across a set of organisations who are looking to integrate, yet they represent business as usual for many of them. We cannot ignore this.

**Don't forget the good examples**

I don't think integration has yet gone as far as we would have liked. That said, there are pockets of good practice which I feel could be better publicised.

In addition, I think we can be too quick to drop our existing examples of best practice the minute they run into a few problems further down the line.

These examples often demonstrate how organisations have thought creatively in pursuing the art of the possible, maybe bending a few rules along the way but achieving a promising outcome. For sure, some subsequently struggle to remain sustainable – or some are unpicked from above – but we should not lose sight of the innovation and entrepreneurship which drove them in the first place.

These are successful outliers who, despite having exactly the same resources as everyone else, have somehow crafted a better outcome for themselves.

This is positive deviance in action – and I think that paying far closer attention to what they did differently could be hugely beneficial for any number of other projects across the NHS. There are so many lessons we could learn.

I keep coming back to relationships as the most important factor behind collaboration and integration though. Issues around money can be overcome within a system if you have relationships in place, based on mutual trust. Without those relationships, the game becomes so much more challenging."

The reminder to think about your partner organisations' "must do" activities resonates strongly with me, bearing in mind my earlier point about needing to build trust quickly among newly formed leadership teams.

The old proverb of not criticising a man until you have walked a mile in his shoes is particularly apposite here. The ability to adhere to what that proverb teaches us is, I believe (and this will come as no great surprise) a characteristic of a strong leader. So too is the willingness to challenge difficult issues head on. At some point, that particular character trait will be tested around the system's current set of financial incentives, many of which appear to actively work against the ethos of a more collaborative system

I touched on this briefly earlier, as did both Nigel Edwards and Sarah Pickup.

However, one colleague of mine – Seb Habibi, a director in our healthcare practice – has some especially strong views on this particular topic.

After Sarah kindly outlined what she thought to be the biggest barriers to collaboration, Seb went further still, suggesting that the thorny issue of the counter-productive financial incentives which currently exist within the system is the single biggest barrier to truly effective collaboration between healthcare service providers. He pulls no punches:

## Sebastian Habibi, Director, KPMG

"The incentives which help oil the current system are a legacy of the previous decade. This was a time when one of the biggest problems facing the NHS was long waits for hospital treatment and when we needed to encourage growth in hospital activity.

The challenges facing the NHS now and for the foreseeable future require a focus on preventing ill-health, supporting people to live independently in their own homes and keeping people out of hospital. This depends on increasing access to care and support outside of hospital and better coordination and care management for people with complex needs.

However, we persist with block contracts that don't reward services for providing more care in the community and that treat care managers as an overhead or financial burden.

Meanwhile, we want hospital clinicians to work with GPs, community nurses and therapists to help keep people out of hospital. Yet the Payment by Results tariff acts as a disincentive by failing to reward hospitals for supporting primary and community care and penalising reductions in hospital admissions.

**Turn it on its head**

To better align financial incentives with the aims of the NHS Five Year Forward View, we need to turn the payment system for hospital and community services completely on its head. In other words, we need to encourage a shift of resources towards improving prevention and increasing access to care and support in the community and away from avoidable hospital use.

International examples of health systems that are succeeding in improving population health and reducing avoidable hospitalisation suggest that government intervention is needed to sort these problems out.

For example, New York State introduced a cap on growth in activity-based income as the first step towards payment reform in its Medicaid system (refer to page 19). These reforms are making continued growth in hospital admissions less and less profitable over time and this is helping to encourage hospital providers to collaborate in reducing avoidable hospital use.

**Naïve thinking**

I think it is naïve to think that this will happen locally in the NHS simply by bringing together different providers under some form of joint governance structure and asking them to manage a single population-based budget.

Moreover, for as long as NHS Improvement chooses to maintain the activity-based national tariff for hospitals, this will remain the default position and will act as a disincentive for hospitals to collaborate to reduce avoidable hospitalisation.

Precedents for addressing the incentives issue can also be found here in the UK. In the Essex Success Regime for example, local commissioners and providers have agreed local arrangements that retain bits of the national pricing rules that work for them and suspend those rules which don't. It's a victory for pragmatism – but this remains the exception, rather than the rule.

But, I would argue that NHS Improvement needs to go much further than this and fundamentally redesign its approach to risk≈assessment.

That's because if we look closely, we see that the current regulatory regime assumes an activity-based business model for NHS hospitals that prioritises hospital income over whole system costs.

This absolutely must change if NHS Improvement is to better enable NHS Trusts to collaborate in integrating services to improve population health and reduce avoidable hospital admissions.

"To better align financial incentives with the aims of the NHS Five Year Forward View, we need to turn the payment system for hospital and community services completely on its head."

# Take me to your leader

**Part 2 by Matt Custance, Partner, KPMG in the UK.**

Issues, issues and more issues; the world of health and social care collaboration appears a bleak place so far. But, that's far from the case. There are great examples of collaboration up and down the country. As Sarah said, of course, more could be made of them.

Let's look at the NHS' vanguard programme. It's an attempt to get integrated, collaborative care to take hold. We spoke to Samantha Jones, Director of New Care Models, for an early season assessment of how the programmes were working.

Sam was keen to point out how new these initiatives still are. The programmes were outlined in March 2015, but many only received their transformational funding eight or nine months ago. She stressed this was worth remembering because time and patience are crucial to the success of these programmes.

For the same reason, it was too early to say which one of the care models being piloted by the vanguards would be the best. It's more likely that different components from each of them will emerge – maybe mixed and matched, perhaps.

**What are the vanguards?**

In January 2015, the NHS invited individual organisations and partnerships to apply to become 'vanguards' for the new care models programme, one of the first steps towards delivering the NHS Five Year Forward View and supporting improvement and integration of services. In total, 50 vanguards were eventually selected, representing five types of new care model.

In March 2015, 29 vanguards were chosen as part of Phase I. These covered integrated primary and acute care systems (joining up GP, hospital, community and mental health services), multi-specialty community providers (moving specialist care out of hospitals and into the community) and enhanced health in care homes (offering older people more joined-up healthcare and rehabilitation services).

Phase II went live in July 2015, with eight more vanguards announced. These eight were urgent and emergency care vanguards, tasked with developing new approaches to improve the coordination of services and to reduce pressure on A&E departments.

Finally, in Phase III – announced in September – a further 13 acute care collaboration vanguards were announced, with the intention of linking local hospitals together to improve their clinical and financial viability as well as reducing any variations in care and efficiency.

What the vanguards are already demonstrating, according to Sam, is the importance of leadership in fostering a culture of collaboration across the health economy. She says:

## Samantha Jones, Director of New Care Models

"Those programmes which have progressed most rapidly are typically those where the relationships between the partner organisations are at their strongest and where everyone agrees on what their core purpose is and how it should be achieved.

That is indicative of strong leaders, focused on the collaborative core purpose, dealing with egos, putting aside individual organisational concerns and taking inspiration from outside of the sphere of traditional NHS organisations.

These leaders are relentlessly focused on what the programme needs to deliver and care far less about what it might look like.

It's a real challenge to do this without doing your own organisation a disservice. However, do not mistake this approach as being weak, passive leadership.

This is simply a different style of leadership and which one will become increasingly prevalent as new collaborative care models emerge.

**Defining the new leader**

This new breed of leader will require a high degree of emotional intelligence, able to listen to – and work with – people at all levels of their organisation. They'll have plenty of humility and won't be averse to taking inspiration from anywhere. They'll be more comfortable with using (and sharing) data to drive decision-making. As a result of all this, they will have the business agility and mental capacity to focus on the needs of today as well as the needs of tomorrow.

We need to remember that a lot of new learning is required to cope with all of this. Many people, like myself, were trained to operate within, and to lead, major health institutions. Leading a system is very different.

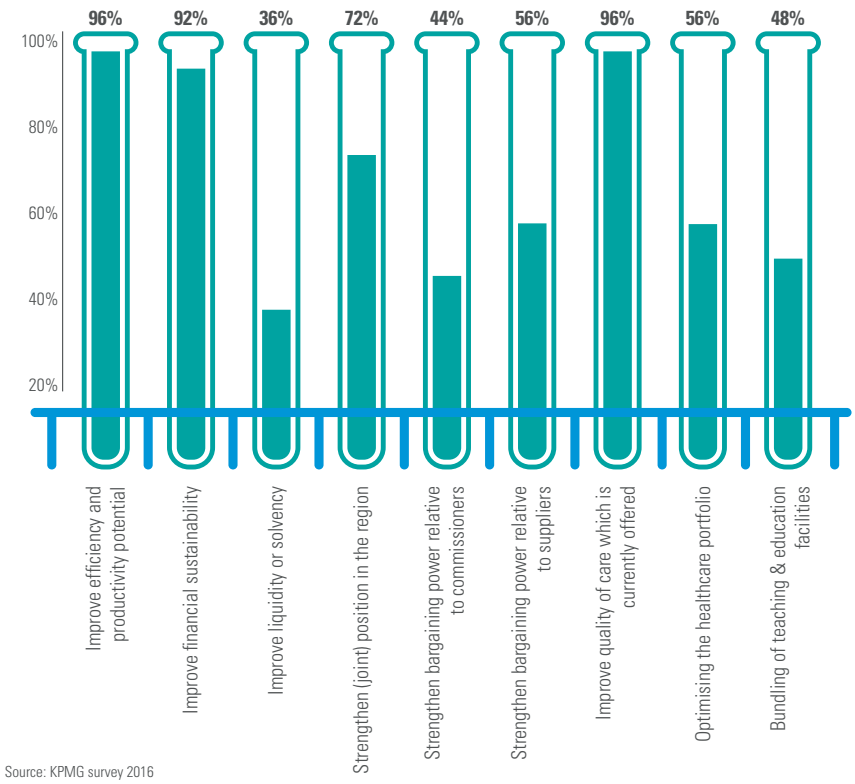
I believe that the NHS has a fantastic leadership cadre, one of the best in the world. It has the ability to address the challenge of integration head-on but will require further support and development.

I think we should also consider how strong leadership can be seen (and needs to be seen) at many different points within an organisation. This isn't just about the senior management team; this is about leaders at all grades. If the latter group is to thrive within a system, not just within their organisation, they too will need support.

We should also remember that collaboration is not just an organisational process. It must involve collaboration with the public, with carers and users playing an active role in helping design the system themselves. Thankfully, we are seeing this across the vanguard programmes.

However, I again come back to my point about needing time. These integrated, collaborative systems must be based on strong relationships. Allowing our system leaders to build those relationships is not something which can be rushed."

### Potential benefits of successful collaboration



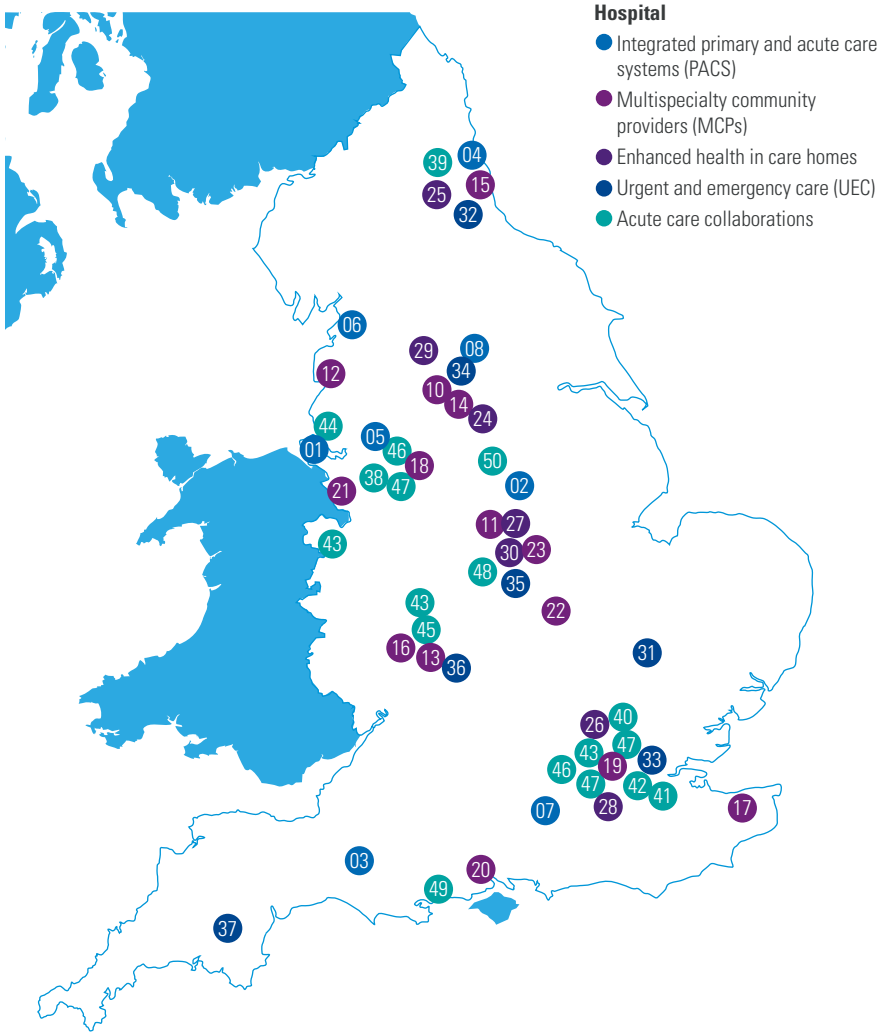

Source: KPMG survey 2016

**Potential benefits of collaboration**

If Sam Jones gets her wish and system leaders are given the time to make a collaborative approach a reality, what will the major benefits be? According to our survey respondents, the top three would be improved quality of care, efficiency and financial sustainability.

"They'll have plenty of humility and won't be averse to taking inspiration from anywhere."

## 50 Vanguards developing their visions locally




### Integrated primary and acute care systems (PACS)

1 Wirral Partners

2 Mid Nottinghamshire Better Together

3 South Somerset Symphony Programme

4 Northumberland Accountable Care Organisation

5 Salford Together

6 Better Care Together (Morecambe)

7 North East Hampshire and Farnham Clinical Commissioning Group

8 Harrogate and Rural District Clinical Commissioning Group

9 My Life a Full Life (Isle of Wight)

### Multispecialty community providers (MCPs)

10 Calderdale Health and Social Care Economy

11 Wellbeing Erewash

12 Fylde Coast Local Health Economy

13 Modality Birmingham and Sandwell

14 West Wakefield Health & Wellbeing Ltd

15 All Together Better Sunderland

16 Dudley Multispecialty Community Provider

17 Encompass (Whitstable, Faversham and Canterbury)

18 Stockport Together

19 Tower Hamlets Integrated Provider Partnership

20 Better Local Care (Southern Hampshire)

21 West Cheshire Way

22 Lakeside Healthcare (Northamptonshire)

23 Principia Partners in Health (Southern Nottinghamshire)

### Enhanced health in care homes

24 Connecting Care Wakefield District

25 Gateshead Care Home Project

26 East and North Hertfordshire Clinical Commissioning Group

27 Nottingham City Clinical Commissioning Group

28 Sutton Homes of Care

29 Airedale & Partners

### Urgent and emergency care (UEC)

30 Greater Nottingham System Resilience Group

31 Cambridgeshire and Peterborough Clinical Commissioning Group

32 East and North Hertfordshire Clinical Commissioning Group

33 Barking and Dagenham, Havering and Redbridge System Resilience Group

34 West Yorkshire Urgent and Emergency Care Network

35 Leicester, Leicestershire & Rutland System Resilience Group

36 Solihull Together for Better Lives

37 South Devon and Torbay System Resilience Group

### Acute care collaborations

38 Salford and Wigan Foundation Chain

39 Northumbria Foundation Group

40 Royal Free London

41 Foundation Healthcare Group (Dartford and Gravesham)

42 National Orthopaedic Alliance

43 Moorfields

44 The Neuro Network (The Walton Centre, Liverpool)

45 Cheshire and Merseyside Women and Children's Services

46 Accountable Clinical Network for Cancer (ACNC)

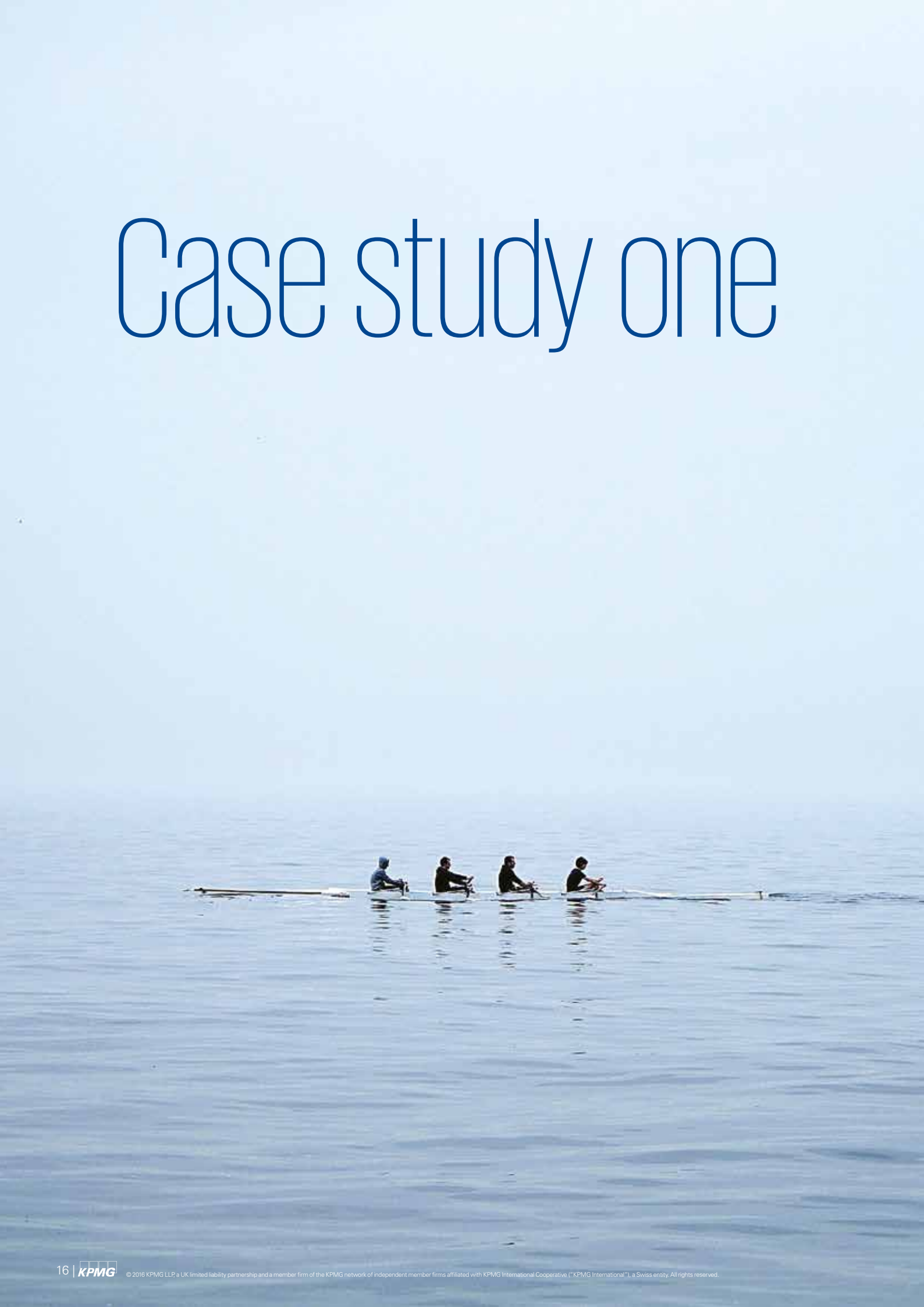
47 EMRAD East Midlands Radiology Consortium

48 Developing One NHS in Dorset

49 Working Together Partnership (South Yorkshire, Mid Yorkshire, North Derbyshire)

50 Cheshire and Merseyside Women and Children's Services

# Case study one



# New York State's transformational journey towards better value and outcomes

In 2014, New York State (NYS) Medicaid prepared itself for a significant transformation. Running one of the highest cost per capita programs in the nation, but with average health outcomes and below average performance in prevention and avoidable costs, led directly to the creation of the Delivery System Reform Incentive Payment (DSRIP) Program.

DSRIP is a model for transformation within Medicaid, the program that provides health insurance for low-income individuals and families. DSRIP's aim is to reform the $60 billion NYS Medicaid program and the services delivered to its six million beneficiaries.

The Affordable Care Act (Obamacare) has allowed states to waive certain rules within Medicaid in order to enable reform. NYS took up this option and was able to reinvest about $8 billion in savings into DSRIP and its reform efforts.

The five year program targets a 25% reduction in avoidable hospital admissions by strengthening prevention and primary care, improving care coordination and aligning care to the patient's needs. NYS took a function-over-form approach, reforming the payments system to align provider incentives to these aims rather than defining the form of how providers must collaborate to address this. By replacing traditional fee-for-service models with value-based payments, healthcare providers were incentivised to participate collaboratively to deliver on patient outcomes.

As a result, the state's 100,000 providers have formed 25 collaborative organizations called 'Performing Provider Systems' (PPSs) which span the health and social care continuum to address patient needs.

These PPSs are able to participate in value-based contracts and are held accountable for the outcomes of their covered population. They participate in shared savings arrangements and measure their progress in delivering better quality care.

The enablement of payment reform has allowed PPSs to design value-based payment models which reflect the patient's needs by episode (e.g., maternity), sub-population (e.g., HIV/AIDS) or chronic condition (e.g., diabetes).

They have been able to design payment models ranging from the incorporation of quality metrics within fee-for-service payments through to more capitated payments. This flexibility in funding allows PPSs to choose their model, based upon their level of comfort with the potential risk and shared savings. They bear the costs of complications, readmissions and rehabilitation themselves but if the cost to deliver care is less than what was contracted, they may keep part of it.

The initiatives which have been enabled by payment reform have shown promising results. These contracting arrangements have allowed PPSs to allocate funding to what best serves the patient's outcomes, including paying for goods or services not typically reimbursable.

In the case of COPD patients, for example, investment in housing improvements for mould prevention reduces the risk of exacerbating their condition and reduces the cost of care. The same applies to the free provision of air conditioning units in the hottest periods of summer for diabetes patients (diabetes being a condition which can be exacerbated by warm and humid conditions).

The health provider will supply the patient with a $200 air conditioning unit to avoid hospital visits that cost ten times as much. A third example is finding housing for the homeless, in order to prevent the emergency room from being used as a shelter.

Successful PPSs have embraced the integration of health and human services, have emphasized preventive and community-based care and have built collaborative networks around the patient.

Ambitious transformation on this scale has required significant support. KPMG has played an integral role in supporting NYS in its transformation journey, providing assistance on a range of topics such as program and policy design, data and analytics and health IT.

**http://www.health.ny.gov/health_care/medicaid/redesign/dsrip/**

# When the eyes of the (healthcare) world turn to Manchester

"Greater Manchester is on a mission to regenerate and rebalance its economy, making it a more valuable contributor to UK plc"

"That vision is an incredibly powerful unifying force"

..."there is a significant benefit to having integration on this scale led by experienced career politicians."

The same people who are looking to the vanguard programmes for pointers as to how collaboration will work in practice will also be looking at developments in Greater Manchester.

If STPs and vanguards will drive collaboration in the healthcare system, so too will devolution. But what can it teach us for healthcare?

Joanna Killian (a KPMG Partner and a local government veteran with 10 years of experience as Essex County Council's CEO), already has a firm view on this. She reminds us of the value of having something which everyone can rally around, not just healthcare providers. Joanna says:

## Joanna Killian, Partner, KPMG

"If Greater Manchester's devolution efforts are to teach us just one thing about better, more integrated healthcare, I'd suggest it would be the motivational value of a higher purpose; something above and beyond the aspiration to "just" improve healthcare provision, however laudable that may be.

Greater Manchester is on a mission to regenerate and rebalance its economy, making it a more valuable contributor to UK plc. In doing so, there is an understanding that there are several issues which need addressing.

Healthcare is just one of them. Greater Manchester knows that a healthy, active, skilled, well-educated and well-housed population is critical to the overall ambition of delivering greater prosperity to the region.

**Inspiring**

It's a hugely inspiring vision, one which fires the imagination and which, more importantly, can get all of the relevant players pulling in the same direction.

This approach is far preferable to the smaller scale, single issue initiatives which typically focus on the symptoms of a problem such as mental health or heart disease. Greater Manchester is focused on tackling the cause, not the symptom.

Poverty, debt, loneliness, homelessness, smoking; these are just a few of the root causes of healthcare issues. But no stand-alone healthcare initiative ever really gets to address root causes such as these. The mandate is always too narrow. This being healthcare, we deal with the presenting symptoms.

Greater Manchester, with its more far reaching aims and ambitions, can attack these root causes. That vision is an incredibly powerful unifying force.

**Workforce challenge**

I can imagine that, on the ground, there will be a significant challenge in bringing together a variety of workforces (each with their own different values, behaviours, processes and approaches).

However, if this can be overcome, I think that the opportunity to help tackle these root causes is one which health and social care workers will actively embrace.

Some of what these people see – and have to deal with on a daily basis – can be wearisome. I can imagine however that the prospect of being able to tackle issues at source will be a hugely energising and motivating force. I think it will also result in these workers bringing more innovative solutions and ideas to the table, unlike now, when they are pretty limited in terms of what they can actually do.

It will be interesting to observe Manchester's inter-meshing of politicians and clinicians and to see how the latter cope, bearing in mind that healthcare has rarely had to operate in such a visible, politicised environment.

Integration on this scale is certainly going to require bold politicians who are used to making tough decisions in the full glare of the public spotlight.

Of course, there is an irony here that, previously, local politicians were typically the most vocal opponents to healthcare changes such as hospital closures. Now they're going to have to get behind any such changes.

Nevertheless, I can see how there is a significant benefit to having integration on this scale led by experienced career politicians. From the point of view of a healthcare organisation, it's certainly better to have them on your side than not."

Someone who has first-hand experience of how the devolution project is progressing is Jon Rouse, the new Chief Officer at the Greater Manchester Health & Social Care Partnership.

When we spoke to Jon, he echoed Joanna's point about the challenge of integrating workforces into one single, system-wide force.

Starting with something of a history lesson, he showed how devolution now gives us the opportunity to settle a 70 year old debate:

## Jon Rouse – Chief Officer, Greater Manchester Health & Social Care Partnership

"It can be argued that over the course of its history, the National Health Service has struggled with the tension between its national identity and the realities of operating at a local level as part of the tapestry of local public services.

Indeed, the tension can be traced right back to post-war Britain when the likes of Herbert Morrison clashed with Nye Bevan over the design of the new NHS, arguing for a local democratic voice to be incorporated into the heart of the new architecture.

Some seventy years on, I think that devolution now provides us with the opportunity to infuse the NHS more strongly with that local democratic voice, empowering people on the ground to decide how best to allocate scarce resource while also abiding by national standards and the NHS Constitution.

It will take time to find the right balance between national and local identity. That is why, in Greater Manchester, we started with a Memorandum of Understanding that led over time to a clear plan which sits within a clear accountability framework and appropriate governance.

**Checks and balances**

There are several checks and balances that should help areas seeking devolution to chart a course over the next few years while preserving the integrity of the NHS' founding principles, respecting patients' rights and freedoms and being properly accountable for how valuable public funds are spent.

The pillars on which we build are the statutory framework, the accountability framework (ultimately to Parliament) and the professional framework (including adherence to clear clinical standards).

This means that in reality we are likely to experience a blend of full devolution of authority (with a permanent shift in accountability), delegation and shared decision-making.

The combination in any given area may change over time but when any change is contemplated, the same questions will need answering – is this legal, who is accountable and is this going to sustain – or even enhance – the right professional practice?

The overlay is system leadership. That is partly about clear governance structures but it is also about personal behaviours with respect to individual and collective leadership. There are many dimensions to how high quality, adaptive leadership can drive system change through new care models but there are perhaps two that I would draw out here.

The first is in respect of the leadership of the health and care workforce; how, over time, to nurture the sense of allegiance to the whole team and the whole system, rather than a single professional group.

The second is to determine how risk – both upside and downside – is shared across the system. The financial implications of both success and failure need to stretch system-wide. An inability to do this may explain why community initiatives which have improved care may have had very little impact on the bottom line in terms of system finances.

**The importance of trust**

The single biggest barrier standing in the way of effective health and care collaboration is, I believe, a lack of trust within the system, and the fear that breeds distrust. Personal relationships between system leaders are crucial – the foundation of any successful system. These usually take years to develop and so continuity is also critical.

Going into my new Greater Manchester role, this is something I am very aware of. Productive relationships are now in place, representing some hard won yards from months of negotiations in the early phases of the devolution project.

The last thing I want to do is to diminish the trust that has built up, disrupting the journey those system leaders have already embarked upon. I will have to be very sensitive in how I approach this.

All of this requires an adaptive leadership approach – i.e. adapting an organisation or system to the external and internal pressures for change.

Perhaps this is something which comes a bit more readily to those executive leaders with a local government background, just because of the realities of working in a political environment and having to manage a cocktail of direct and indirect relationships which cut across sectoral and agency boundaries.

System leadership also requires a healthy dose of pragmatism. I don't think this is the time for pre-determined views on structures or governance.

I think this is the time for creating models which are clear in terms of accountabilities but also suitably flexible so that the various participants can play in different ways and at different speeds.

This may result in delivery models which are messier than might be deemed ideal. But perhaps that is just a price that needs to be paid to get everyone we need inside the tent, to create the coalition of the willing that will take us forward.

# Choose your vehicle

**43%** strategic alliances

**39%** clinical networks

**18%** buddying

Of the 49 instances of informal collaboration which our survey respondents claimed to have been involved with since the start of 2015, strategic alliances were the most popular choice (43 percent of respondents were involved in one), followed by clinical networks (39 percent) and buddying (18 percent).

It feels as if we've covered the topic of system leadership quite extensively now. But assuming that our new breed of strong, empathetic leaders can get everyone marching to the same drumbeat, what form will that collaboration take? Will people work together through informal collaboration like strategic alliances or clinical networks? Or through contractual arrangements or organisational consolidation?

Forty percent of our respondents expect to participate in a formal merger.

This sounds right to me. I think increased M&A will be driven by four factors: new care models to integrate and streamline care, economies of scale, leadership and failure.

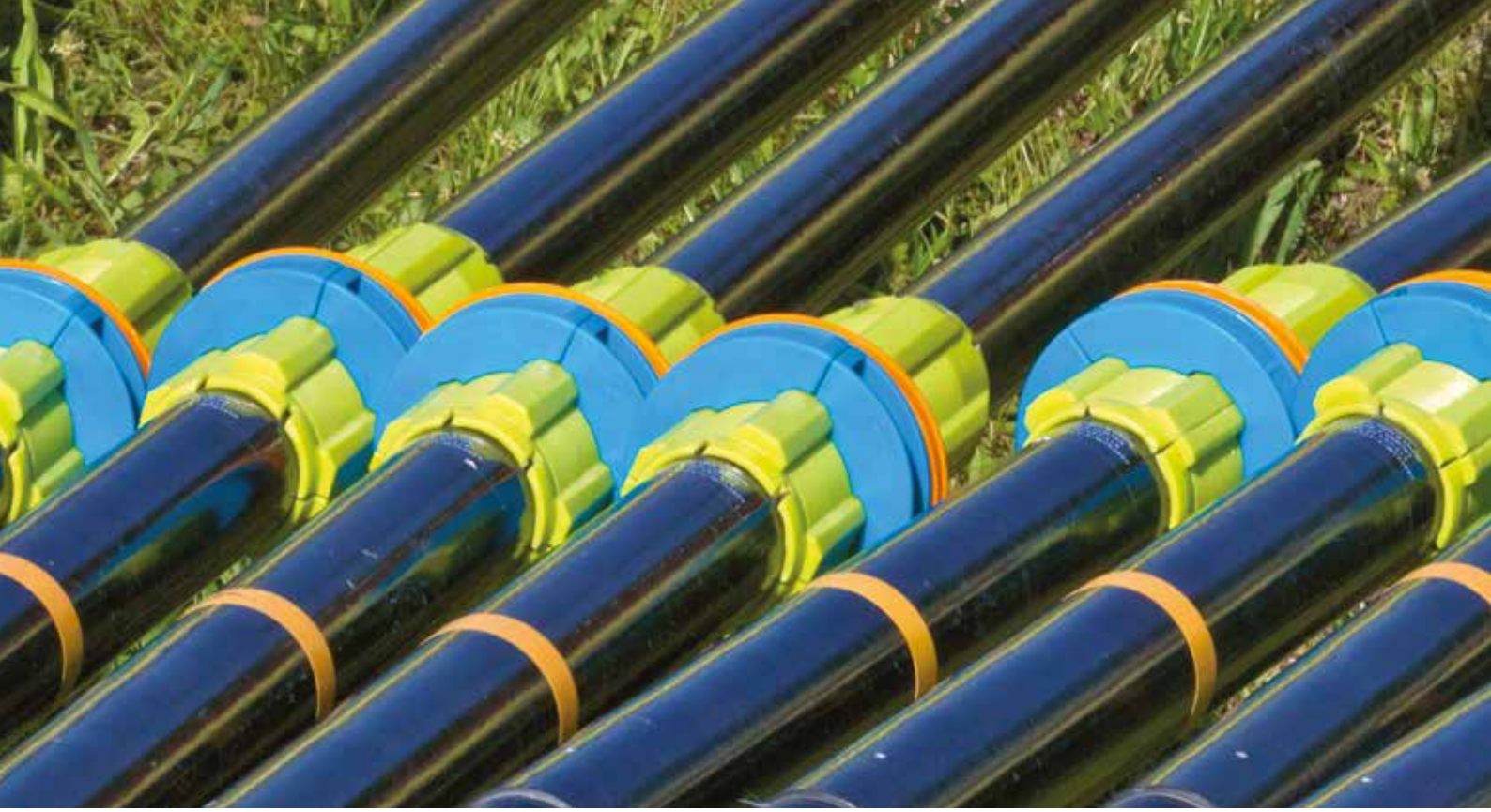
Let's start with new care models. If we want a more integrated healthcare solution, the old boundaries between and within health and social care provision will become unhelpful.

Primary care centres will start to look like small district general hospitals. Physical and mental health need to work more closely as a single offer. Primary care is already in hospitals and hospital consultants are starting to offer services in the community. M&A activity can accelerate the demise of those boundaries.

Scale is also an obvious driver. We know that there are economies of scale, especially in specialist care, and the accepted view for the "minimum" size of a successful acute keeps going up.

However, these arguments about scale are starting to be replaced with arguments about leadership.

It has become commonly accepted in the NHS that we lack enough high quality leaders (60 percent of our survey respondents agree with this) – so M&A allows that limited pool of leadership talent to increase the field of their impact.



Fewer organisations means a requirement for fewer CEO's. So the existing small cadre of genuinely excellent leaders would be less thinly diluted across the sector and better able to work their operational magic.

**Where have all the leaders gone?**

It's worth though reflecting on why we might have a small pool of talented leaders. The NHS is much more about accountability than it is about excellence. That means it's a very risk averse service. Put a foot wrong as an NHS CEO and you'll lose your job.

There are many examples of good leadership development in the NHS from informal, individual coaching to major programmes like the NHS Leadership Academy. But too often leaders in the NHS are not supported well when they face difficult challenges or take well intended bold decisions and fail. Too often leaders are moved on to new roles when support to them and their organisations could perhaps better resolve the problems. This movement creates a constant "merry-go-round" where leaders are afraid to act in the face of challenges. It creates a risk-averse culture and limited organisational ambition. It means leaders are sanctioned not supported and we should therefore not be surprised that too few come through with the skills and resilience to master the challenges the NHS faces now.

We also shouldn't be surprised that great leadership fails to develop in a system where we don't trust our executives or even our Boards. Controls from the centre are increasing.

We don't trust our organisations' governance enough to allow them to recruit locums, advisers or make major capital or operational investments without control from the centre.

There is then of course failure. Sadly, you can't talk about the NHS at the moment without mentioning the widespread failure, mostly financial but also operational and in some cases clinical. Sadly this is also a driver for M&A – a means to revive a failing organisation by injecting the culture, financial controls, clinical governance or scale of another.

**The pursuit of excellence**

However, there is another driver for mergers which we see less often at the moment – but I hope we will start to see more of. I hope that we will start to see M&A activity that is driven by the pursuit of excellence, rather than as the remedy for failure which it traditionally has been.

In the private sector, mergers and joint ventures are typically seen as a way of promoting excellence and delivering business growth, taking the best of two organisations and turning them into one, even better, single entity. We don't see that so much in the public sector.

Overseas, you can find leading academic health science centres which would dwarf anything comparable in this country. Why don't more of the UK's biggest organisations come together, scaling up to be similarly world class on the global stage? The answer, I suspect, lies in the sense that they're doing well enough on their own, thank you very much; that they're sufficiently successful on the UK stage. Why risk it?

I think that's a complacent approach – but is also indicative of how the UK healthcare sector is driven more by risk aversion than by the pursuit of excellence. It's managed and governed to be that way.

"Why don't more of the UK's biggest organisations come together, scaling up to be similarly world class on the global stage?"

# There is another way

Nevertheless, excellence can be found – and there are some really good examples of where M&A activity has delivered strong results within the healthcare sector. One such example can be found in West London.

On 1 September 2015, the Chelsea and Westminster Hospital NHS Foundation Trust acquired the West Middlesex University Hospital NHS Trust. Formally appointed as the Foundation Trust's chief executive just two weeks later, Lesley Watts was pitched straight into overseeing the merger.

Less than a year on, she shared with us a few of the insights from creating an organisation which employs some 5000 staff and caters for a local population of around one million people.

## Lesley Watts, Chief Executive, Chelsea and Westminster Hospital NHS Foundation Trust

"Although the newly merged Trust is not even a year old yet, early indications are that the merger has been a success. What really helped in this regard is that, from the outset, there was an obvious willingness to make this work.

There was a noticeable generosity of spirit in the initial leadership exchanges with the Board of the West Middlesex Trust, accompanied by a sense that everyone was pulling in the same direction, working for a common cause; namely the well-being of our local populations and our staff.

It was important to match this generosity. Legally, this was an acquisition but as soon as we possibly could (once the transaction process had passed the Competition Market Authority tests), we looked to rebrand the whole acquisition process as an Integration Programme. Bearing in mind the importance of culture and identity, we looked for ways of highlighting the partnership dynamic and our mutual values.

There was a similarly warm welcome from West Middlesex's existing partners. As a result, we were able to talk, listen and get advice from all these other players who hold a similar stake in the local population's well-being, continually looking for examples of best practice in productivity and efficiency which we could replicate.

The importance of having such willing partners cannot be underestimated. It is the bedrock on which our early successes have been built.

It was equally important to secure clinical engagement as quickly as possible, ensuring that the clinicians were comfortable with what's going on.

Six clinical summits, held over an eight month period leading up to Day 1, really helped us in this regard, demonstrating that clinical services lay at the heart of what we were trying to achieve and that the clinical (and support) community would be at the centre of the new organisation.

This allowed relationships to develop and meant that plans for, among other things, new surgical structures could be enacted rapidly post-merger.

### Addressing misconceptions

Once the merger became a reality, I think there was a perception that ours might become a Chelsea-dominated organisation.

This gave rise to understandable concern about the West Middlesex staff being left on the periphery – as if the merger was something that would simply happen to them. We wanted to dispel these perceptions as soon as possible. Both organisations had things to learn from the other. We wanted to make that point, while also stressing how both organisations cater for London at its most diverse best.

I like to think that the strategy and insights we articulated did resonate with the West Middlesex staff. Shortly thereafter, in a national staff survey, West Middlesex registered one of the highest upswings in staff engagement nationwide, something that could be seen as evidence of a reassured and reinvigorated workforce. It is also typically linked to an improved patient experience and clinical outcomes.

The lesson learned here was that you can never communicate too much. Make sure that your message gets across but also keep refining that message as some of the meaning inevitably gets lost in translation.

### The value of being different

I think it was also important to recognise and embrace the differences between the two organisations. There are deep-seated historic reasons for those differences, some of which can prove highly valuable.

I always felt that West Middlesex had more of a community feel about it, for example, borne out of the fact that more of the staff live in the immediate area than is the case at Chelsea and Westminster.

## Lesley Watts, Chief Executive, Chelsea and Westminster Hospital NHS Foundation Trust continued...

"Trying to make changes purely to bring about a degree of standardisation between the two organisations could have proved damaging to something like that sense of community. Leaving certain things alone could again act as a reassurance to staff that upheaval for the sake of it was not on the cards.

Standardisation is something you only pursue where it makes sense. For us, this has happened in finance and HR and there are ongoing discussions about continuing this throughout the back office functions.

There are occasions however when standardisation might not be appropriate. That's perfectly acceptable but a conscious decision has to be made for that difference to be allowed to persist.

**Maintain the quality of care**

Away from all the planning and theorising, what we wanted to demonstrate from the outset of the integration process was that we were concentrating on what really mattered; the provision of great care. Care standards would not be allowed to dip and access targets would be maintained.

Thankfully, we achieved that particular objective, maintaining the best A&E performance in London during the merger process (see fig 1 below), as well as performing well on cancer and elective surgery waiting times. It was important to show that the integration and all of its attendant activities did not distract our focus from what really matters.

Getting the system management and patient access priorities right buys you the freedom to go and do other things, to improve elsewhere. Get it wrong and extra scrutiny follows; something which can prove distracting.

Interestingly, in the honeymoon period following the merger, a friendly rivalry emerged between departments at the two organisations in terms of who was doing the best job of maintaining or improving those quality standards. Over time, that morphed into a willingness to help each other out to maintain that provision of care.

As our merged entity's care model develops, it's important that the various specialisms are empowered to help design the "how" and the "what" of their own particular offering from the bottom up. The goodwill being generated across departments right now is helping to lay the foundations for the discussions around how those services might subsequently be redesigned.

Management shouldn't hide

While communication is important, so too is management visibility. We have committed to getting the management group out onto the healthcare front line, pitching in with the staff for one day every month, as part of an initiative called The Perfect Day. It has been good for management to see first-hand how things are working on the ground. It has also been good for morale and has helped management to connect and empathise with staff and patients.

Not all of our senior managers are clinically trained so this has been both an unusual and rewarding experience for them. For example, one director recounts how he feared simply getting in the way when he was out on the wards.

However, he is also quick to point out that he found even the simple act of helping get a patient into a hoist to be incredibly rewarding; something which meant he felt vaguely useful and therefore part of the team. After that, the other staff opened up about some of the problems they faced and he was able to follow up with some small changes that have had a direct impact. That's what it is all about.

In the same vein, the executive team has moved out of their separate offices, saving money by doing so but also demonstrating that we are all in this together.

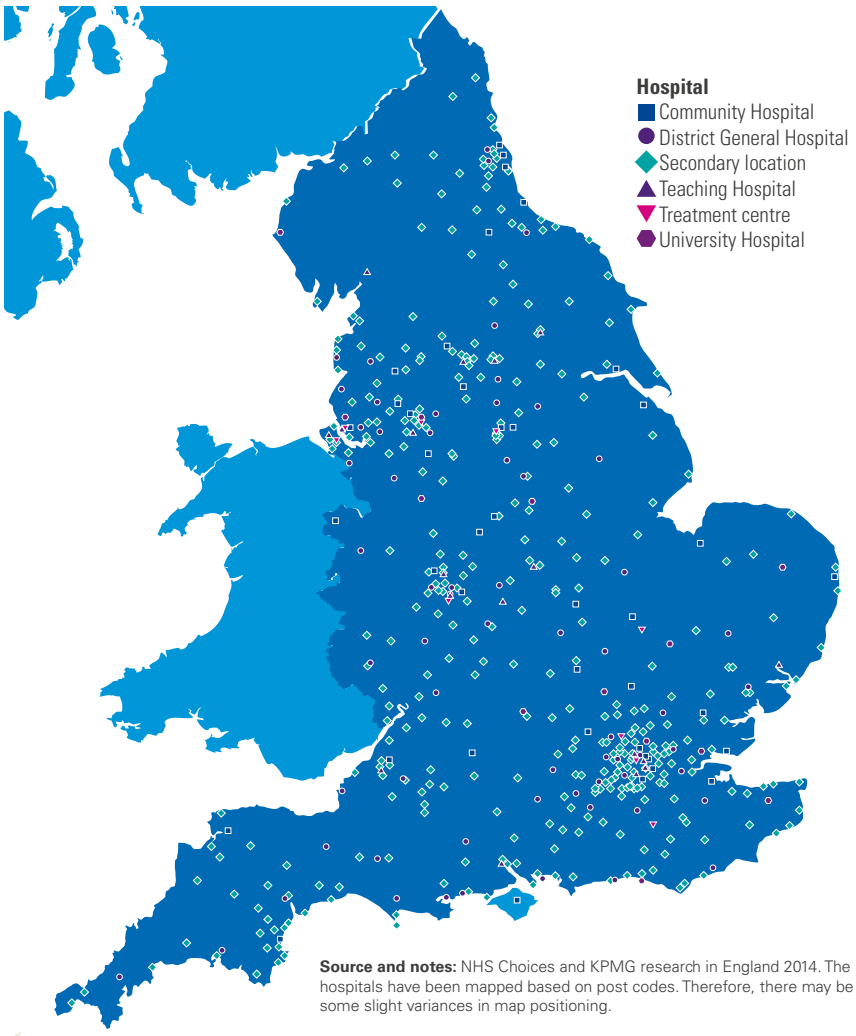
Recent shifts in national policy mean that the environment within which hospitals and their partners operate has definitely changed. It feels very different now; much more conducive to working together collaboratively. That's a better backdrop against which to embark upon a merger – although it's still a hugely complex task.

My advice to anyone going through the merger process would be to ensure that the acquired organisation absolutely understands what underpins the acquire's approach. Articulate the benefits of this to staff and engage them early. Be aware that negativity among the senior staff can have a huge impact and, above all, have a sense of realism and don't try to change everything. Achieving what you said you would in the first 100 days, or in the first year, gives you the credibility and momentum to continue to move forward."

**Fig 1: Performance by site, by Trust total against national 4h access target**

| Site | Sep 15 | Oct 15 | Nov 15 | Dec 15 | Jan 16 | Feb 16 | Mar 16 | Apr 16 | May 16 | Jun 16 |
|---|---|---|---|---|---|---|---|---|---|---|
| WM | 96.8 | 96.7 | 94.3 | 95.0 | 95.6 | 93.7 | 93.8 | 95.0 | 96.3 | 95.6 |
| CW | 94.7 | 97.1 | 95.7 | 95.9 | 95.1 | 94.1 | 93.6 | 93.3 | 95.1 | 95.8 |
| Trust | 95.9 | 96.9 | 94.9 | 95.4 | 95.4 | 93.9 | 93.7 | 94.2 | 95.8 | 95.7 |

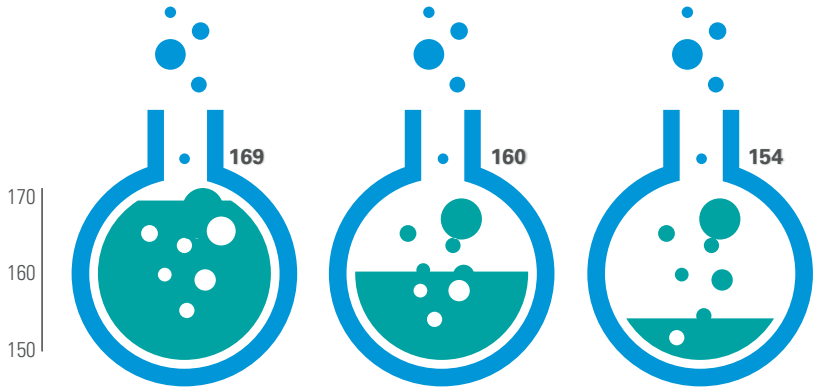
## An overview of Acute Trusts and Foundation Trusts as per 2016.




**Source and notes:** NHS Choices and KPMG research in England 2014. The hospitals have been mapped based on post codes. Therefore, there may be some slight variances in map positioning.

The role played by M&A so far. By 2014, there were nine fewer independent acute or foundation trusts than in 2008; 160 compared to 169. The total number of independent Acute Trusts has dropped more again from 2014 to 154 in 2016.

## The net impact of rationalisation and merger activity on the UK's independent Acute and Foundation Trusts




# Case study two

## We can't do everything ourselves any more

**Karolinksa and Philips:**

Karolinska University Hospital is a major academic hospital in Stockholm and is a global leader where collaboration with the med-tech sector is concerned. Karolinska has had a partnership with Philips for the past one and a half years. Karolinska's head of strategic innovation, Stefan Vlachos, told us all about it.

"In Sweden", he explained, "healthcare costs are rising too fast and there is a desire for more value-based procurement and provision of care. One thing we knew for sure when we started on this was that we could not do everything ourselves, not even as an Academic Health Science Centre. We have patients, we have medical staff and support but we cannot develop the machines or technical applications that are needed to improve the care we provide. Hence this partnership with Philips came about, focusing on intelligent procurement on the one hand and on shared development of care programmes on the other."

In terms of how the partnership was actually established, Stefan said: "For our programme, we have a shared responsibility and the contract has a shared governance structure. Of course, there is always a cultural tension between a private company and public one. Sometimes, it is difficult to determine the fine line between innovation and scientific research. What innovation will look like, exactly, is still difficult to say at this stage. We do not want to put any limitations on this definition right now."

"The main part of the contract, approximately 85% of the purchase value, concerns the provision and management of equipment by Philips. They do not guarantee that the latest equipment will be in our hospital, but it will be the best given our own profile. The second part covers procurement aimed at optimising care programmes for patients who have suffered a stroke. This part naturally attracts attention, as it is directed towards collaboration in the actual provision of healthcare for the patient."

"The breakdown of financial benefits between Karolinska and Philips as a formula is quite simple: cost reduction times quality improvement times scale. The difficult part is how to measure all this and according to which parameters. Providing the underlying data is the most difficult part and we still have much to sort out on this."

In terms of the long-term ambition for a partnership which is still in its infancy, Stefan concluded: "It is very ambitious. We want to improve health outcomes for the entire region around Stockholm. Furthermore, our clinical staff, who are closest to the patients, can show Philips their daily routine and give instructions on issues that Philips could address or perform research on. This way, we can help an organisation such as Philips to optimise its research budget, which in turn will benefit the patient."

# When the STP met the GP

Looking back across all the interviews we conducted for the purpose of this report, there tended to be a focus on acute care and community care when it came to talking about collaboration and system transformation.

Our final interviewee took issue with that. Rob Vickers is the CEO of Digital Life Sciences, a company looking to deliver healthcare in different ways through increased adoption of digital and online technologies.

As far as Rob is concerned, the STPs represent a wonderful opportunity to overhaul primary care in this country – but he fears that it's an opportunity which will be largely overlooked:

> ..."no-one is profiting from this excess demand because most patients are mismatched to the wrong resource."

> "Within primary care, this resource mismatch is hugely damaging, economically."

## Rob Vickers, Chief Executive Officer, Digital Life Sciences

"I don't get the feeling that many of the STPs have really considered how disruption in the primary care space could drive efficiency and sustainability throughout the entire healthcare system.

As I don't think that many people understand the economic argument for disrupting primary care, I therefore don't expect it to feature enough in many of the first round of plans.

For that reason, I fear the emergence of too many hospital-driven strategies, focused on things like managing the front door, discharging patients or transferring care into the community. This is despite the fact that overhauling primary care could actually deliver the reduction in hospital admissions that so many crave.

Primary care is where the bulk of the UK's healthcare service is delivered. It is also the least resilient and most inefficient part of the system. That's because it doesn't currently operate at the scale required to do the job it is supposed to – and because it works to a flawed economic model.

**Mismatched**

Sadly, many of our smaller, high street primary care practices are now slowly going bust. This is perverse at a time when patient demand is outstripping supply. Yet no-one is profiting from this excess demand because most patients are mismatched to the wrong resource.

Appropriate access to primary care (whether that be a nurse, pharmacist or GP) is what will make the difference – and there is a simple economic argument for doing this.

I would estimate that 60-65 percent of the people in a typical primary care practice don't need to see a GP – yet they do. What an inefficient use of the time of most highly trained person at the practice. Primary care should be structured around a workforce model, with the GP at the top and other suitable care providers slotted in beneath.

Appropriate multi-disciplinary resource, available at an appropriate scale (e.g. serving tens of thousands of patients, rather than a few thousand), accessible via a variety of different channels (online, face-to-face, mobile); this is how modern day primary care should be delivered.

**Learn from the bankers**

Retail banks have the right idea. If everyone going into a bank had to see the bank manager, you'd soon have a lot of disgruntled customers and profitability would plummet.

As it is, the vast majority of people engaging with a bank can do so with no human interaction whatsoever. An appropriate interface – online, phone, ATM – can do the job. By pointing us in the direction of the most appropriate interface, the bank actually gets us to do most of the work.

What this means is that very few people actually see a banker. This "privilege" can be reserved for higher value customers such as business account holders or people arranging a mortgage. The economic argument for letting them use up valuable staff face time is clear. In such a model, you can also afford to employ fewer highly paid individuals while delivering a more profitable, sustainable model.

Within primary care, this resource mismatch is hugely damaging, economically. Patients who are unable to access their own expensive resource (their GP), end up using other parts of the system, such as out-of-hours services, walk-in centres or A&E, which are just as expensive, if not more.

**Give the GP a break**

All of this stems from the incorrect belief that the GP has to do everything. Address this issue by offering more appropriate access to primary care and I believe that we could reduce the A&E burden alone by a quarter.

Even where the resourcing model is being addressed, too many primary care operators are still thinking like small businesses. They are not actively looking to scale up their activity like a larger business or a PLC might do. This is critically important to making a revised resource model economically viable. As an aside, there is something of an irony when people talk about how the NHS can't be privatised.

Within primary care, it already is. People think of this as a public service but primary care comes from private businesses operating a public service.

For this reason, they should be positively encouraged to think in more corporate terms about their long-term economic viability. All of which brings me back to the STPs. If they focus solely on the acute care front line, then we'll still end up with a system which is too expensive. If we want to keep people out of hospital, then it's primary care where our focus should lie.

The STP should be a catalyst for thinking about how changes to primary care could provide the necessary disruption required to enable system-wide transformation. In particular, I don't see the STPs solving anything unless they tackle the issue of 'right-sizing' primary care. This is the time for thinking about what primary care could or should be, rather than fiddling with what it is now.

This will only happen in geographies where there is a decent level of maturity within the primary care system. This means GPs being open-minded about change but also patients not thinking that what's on offer in the nearest clinic must be the best they can get. This is a competitive market.

The public policy and the ambition behind the STPs is sound. The reticence for tackling primary care – and the difficulty of implementing changes on the ground – is what will get in the way of them being deemed a success."

# Summary

So, where does all this leave society in terms of plotting a way forward for UK healthcare and in particular for the new breed of system leaders required to lead the way? Revisiting some of the recommendations and observations from our various contributors, a wishlist emerges:

- Investment in systemic leadership skills development;
- A commitment to addressing the issue of perverse financial incentives by shifting from volume payments to value payments;
- Clarify how the system leaders will be held to account for system transformation and how they will be supported to do it;
- A new approach to workforce, focusing on a single, system-wide workforce plan, all pursuing a single, shared set of objectives;
- Use disruption in primary care to drive productivity and efficiency improvements across the system;
- Be patient, allowing system leaders sufficient time to learn new skills and to adapt to the requirements of their new role;
- Be pragmatic, not foisting predetermined views on structure or governance onto the new systems;
- When the process of stitching together the various healthcare providers begins, ensure that the rationale is right;

Over the course of the entire piece, it's easy to lose count of the number of occasions which mention time, trust, relationships and leadership style. We think the best summary of this came in a couple of soundbites from Sam Jones and Sarah Pickup respectively:

"It's a real challenge to do this [to remain resolutely focused on the collaborative core purpose] without doing your own organisation a disservice. However, do not mistake this approach as being weak, passive leadership. This is simply a different style of leadership and which one will become increasingly prevalent as new collaborative care models emerge…

These integrated, collaborative systems must be based on strong relationships. Allowing our system leaders to build those relationships is not something which can be rushed."

"I keep coming back to relationships as the most important factor behind collaboration and integration. Issues around money can be overcome within a system if you have relationships in place, based on mutual trust. Without those relationships, the game becomes so much more challenging."

As Beccy said, system-wide leadership is a game-changer. There are crucial points to consider around incentives, collaboration vehicles and the STPs but failure to get the leadership point right, could mean it's harder to see what can really be achieved.

# Methodology

The observations and conclusions in this publication are partly based on publically available sources, and experiences in KPMG's Audit, Tax and Advisory practice. In addition, a survey was conducted amongst CEOs of Acute Trusts and Foundation Trusts in England. Twenty five CEOs completed the survey. Furthermore, interviews were held with seven 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.

# Acknowledgements

We would especially like to thank the following people for their valuable contribution to this study.

All interview participants: Sir Robert Naylor, Lesley Watts, Nigel Edwards, Sarah Pickup, Samantha Jones, Jon Rouse and Rob Vickers

The KPMG project team: Beccy Fenton, Lous Klomp, Matthew Custance, Hannah Butcher and Gemma Fawl.

KPMG firms' Partners and Directors interviewed: Joanna Killian and Sebastian Habibi.

Writers: Beccy Fenton, Matthew Custance and Lous Klomp.

# References

**Desktop research – public sources**


1. https://www.thewaltoncentre.nhs.uk/PageInfo.aspx?6/about-us.html
2. http://www.pat.nhs.uk/about-us/
3. http://www.nhs.uk/servicedirectories/pages/nhstrustlisting.aspx
4. http://www.nhsconfed.org/resources/key-statistics-on-the-nhs
5. https://www.gov.uk/government/publications/nhs-foundation-trust-directory/nhs-foundation-trust-directory
6. http://www.health.ny.gov/health_care/medicaid/redesign/dsrip/
7. 'New Care Models, Vanguards – developing a blueprint for the future of NHS and care services', NHS, March 2016 https://www.england.nhs.uk/wp-content/uploads/2015/11/new_care_models.pdf 'Sustainability and Transformation Plan Agenda', April 2016
8. 'Sustainability and Transformation Plan Agenda', April 2016, http://democracy.merton.gov.uk/documents/s12152/Item%2007%20-%20STP.pdf
9. 'Developing Sustainability and Transformation Plans', March 2016, http://www.local.gov.uk/documents/10180/5572443/health+-+integration+-+STP+April+submission+support+and+template+15+March.pdf/26f3601e-043d-4740-9ac8-310939f0e12f
10. 'NHS Five Year Forward View: New care models' – update, August 2015, https://www.google.co.in/url?sa=t&rct=j&q=&esrc=s&source=web&cd=3&cad=rja&uact= 8&ved=0ahUKEwj6II2x84HNAhVR62MKHbhVDXAQFggpMAI&url=http://www.doncasterlmc.co.uk/NCM%20update%20Aug15.pptx&usg=AFQjCNHiqHHQg7SAF8z OK21bJ4i8GpKc8w
11. 'It's been an inspirational year of change' – Samantha Jones, March 2016, https://www.england.nhs.uk/2016/03/samantha-jones-2/
12. Case Study 1: Helping drive multispecialty community provider (MCP) vanguards forward – Louise Watson, March 2016, https://www.england.nhs.uk/2016/03/louise-watson/
13. Case Study 2: Nursing a person, not just their illnesses – care home manager Joy Allen, March 2016, https://www.england.nhs.uk/2016/03/joy-allen/
14. Case Study 3: Best care will come from collaboration not competition – Jeff Johnston, March 2016, https://www.england.nhs.uk/2016/03/jeff-johnston/
15. How will services access the new Sustainability and Transformation Fund?, The King's Fund, January 2016, http://www.kingsfund.org.uk/blog/2016/01/sustainability-and-transformation-fund

16. Greater Manchester Cancer Vanguard, Christie, http://www.christie.nhs.uk/about-us/our-future/our-partnerships/greater-manchester-cancer-vanguard/

17. London Cancer and the national cancer vanguard, London cancer, http://londoncancer.org/about/governance/

18. RM Partners Cancer Vanguard, Royal Marsden, https://www.royalmarsden.nhs.uk/about-royal-marsden/who-we-are/rm-partners-cancer-vanguard

**KPMG Survey 2016**

A survey was conducted amongst CEOs of Acute Trusts and Foundation Trusts in England. Twenty five CEOs have completed the survey.

**Interviews**

Sir Robert Naylor, Chief Executive at University London College Hospitals

Nigel Edwards, Chief Executive at Nuffield Trust

Sarah Pickup, Deputy Chief Executive at Local Government Association

Samantha Jones, Director of New Care Models

Jon Rouse, Chief Officer at Greater Manchester Health & Social Care Partnership

Lesley Watts, Chief Executive at Chelsea and Westminster Hospital NHS Foundation Trust

Rob Vickers, Chief Executive Officer at Digital Life Sciences

# Our team

At KPMG we understand key industry issues. Below is a list of our skilled professionals and their areas of expertise:

**Matthew Custance – Partner**
M&A (including organisational form)
t:+ 44 (0)7739 875320
e: matthew.custance@kpmg.co.uk

**Beccy Fenton – Partner**
Care system redesign
Workforce
Leadership development & systematic coaching
System workforce transformation
t:+ 44 (0)7584 272620
e: beccy.fenton@kpmg.co.uk

**Sebastian Habibi – Director**
Learning from New York State Payment Reform
t:+ 44 (0)7801 106754
e: sebastian.habibi@kpmg.co.uk

**John Howard – Partner**
Aligning financial incentives
Learning from New York State Payment Reform
t:+ 44 (0)7810 554143
e: john.howard@kpmg.co.uk

**Joanna Killian – Head of Local Government**
Public Sector Inspiration & Devolution
t:+ 44 (0)7920 560308
e: joanna.killian@kpmg.co.uk

**Jason Parker**
Partner, KPMG LLP
UK Head of Healthcare
**t:** + 44 (0)7867 550352
**e:** jason.parker@kpmg.co.uk

**Beccy Fenton**
Partner, KPMG LLP
**t:**+ 44 (0)7584 272620
**e:** beccy.fenton@kpmg.co.uk

**Matthew Custance**
Partner, KPMG LLP
**t:**+ 44 (0)7739 875320
**e:** matthew.custance@kpmg.co.uk


CRT062576 | October 2016

Share your views and join the debate:

Visit us
**kpmg.com/uk/healthcare**

Email us
**publicsectormarketing@kpmg.co.uk**

Engage with us
Follow us on Twitter @
**KPMGUK**