Department of Health

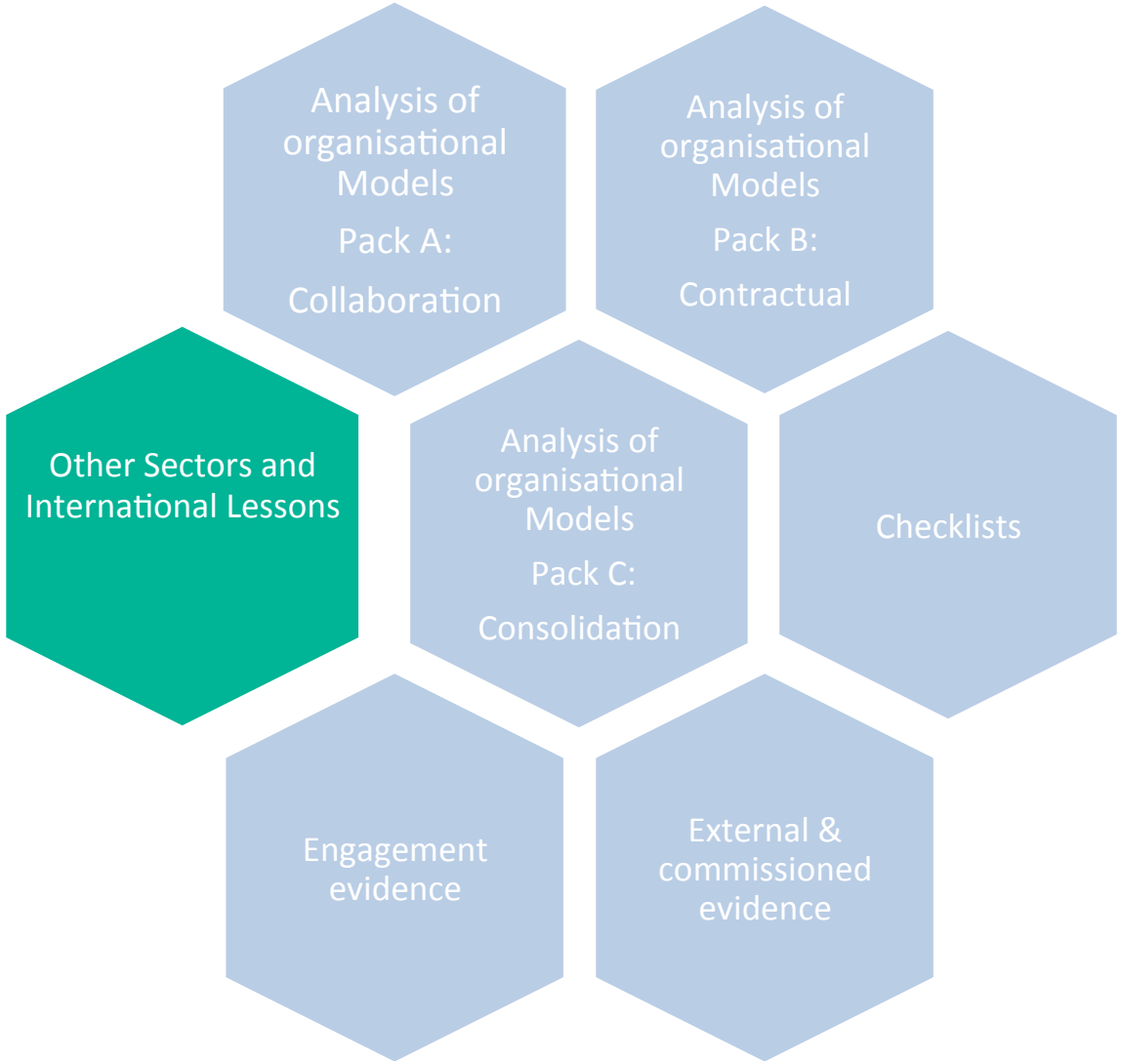
Dalton Review

Lessons from other Sectors and international experience

December 2014

Contents

The key below outlines the supporting evidence to the Dalton Review: each pack is self-contained and can be read as a stand-alone document. This blend of evidence gathering, commissioned research and engagement feedback supports the recommendations of the Review.



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Lessons from other sectors and international experience

Evidence base

To build learning lessons from other sectors and international experience two main sources of evidence were used

Research	The Nuffield Trust were commissioned to review the corporate practices of organisations operating a group/ chain structure in sectors outside the NHS, along with historic NHS experience, to see what lessons could be learned. The research distils learning from interviews with senior leaders of multi-site organisations to produce a set of lessons for the NHS about what makes a successful chain operation. RAND Europe was commissioned as part of an 'call-off' facility for International Healthcare Comparisons for the Department of Health. The research considers how different hospital 'models' in Europe and the US may provide lessons for hospital provision in England. The methodology is an exploratory analysis of four countries: France, Germany, Ireland and the US.
Qualitative Case Studies	An extensive programme of international visits and workshops were organised to gain insights and practical knowledge of how hospitals operate in other countries, with a particular focus on organisations operating hospital chain/ group structures and integrated care organisations. The following research areas were explored with international providers: • Enterprise structures and strategies for organisational development; • The motivations and drivers behind chains, groups and integrated care models; • The challenges and barriers faced in organisational development; • Strategies for the creation of value (e.g. standardisation); • The creation of a collective, organisational culture and values; • Applicable lessons for the UK.

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Lessons from other sectors and international experience

Research Findings – The Nuffield Trust

The long term opportunities that effective multi-site chain models appear to offer to generate and disperse innovative and high quality practice are attractive and merit further exploration by the NHS

- The Nuffield Trust research finds that operating across multiple sites requires a shift to a management system with a corporate centre and outposts, rather than appending an acquired institution onto an existing organisation.
- Operating a successful multi-site organisation requires different systems and management approaches from those deployed within a single site organisation.
- The corporate centre will have different objectives from individual business units and delivering these will require different skills.
- Running an effective multi-site organisation requires extensive formalisation and standardisation of operating procedures, management systems and functions.
- Most organisations have identified a set of core functions including governance, procurement, HR and payroll, IT and estates and property management, that are delivered by the corporate centre or at a regional level in larger organisations.
- Communications and brand management are also generally managed centrally.
- Effective chains have clear processes in place for internal quality audit, in order to ensure compliance with governance requirements.
- Almost all chain organisations have processes to systemise the spread of innovation. They also have a rigorous roll-out process once an innovative approach had been approved for adoption.
- The level of investment in pre-integration planning and post-acquisition organisational change to add additional units to the chain was usually significant, extremely rapid and on a large scale using a significant amount of managerial resource.
- The research highlights two distinct lessons. The first set of lessons reinforces existing knowledge about the importance of strong merger and acquisition processes. The second set of lessons points towards the potential for a significantly changed approach to operational management within the NHS, which is different culturally, operationally and structurally.

Research Findings – RAND

The hospital landscape in Europe and elsewhere is diverse and changing; the NHS can learn from innovative organisation models from abroad

- The RAND Europe research finds there are some common trends that can be observed across international health systems. For example, among public hospitals in tax-funded systems, there has been a move away from centralised political control towards the introduction of a greater degree of institutional autonomy and the use of market incentives. Many countries have departed from the traditional approach of using global budgets for paying hospitals towards introducing activity-based funding.
- The nature of hospital activity is changing in many countries, with some experiencing a broader trend towards the creation of hospitals groups or chains and multi-hospital networks, particularly in the United States, and, more recently, in European countries.
- There is an expectation that the formation of hospital groups and networks will lead to greater market influence, economies of scale and scope, reduced duplication of resources, more effective training, and improved efficiency in the provision of services, among other motivations.
- This has contributed to changes in the structure of hospital activity with a broader trend towards hospital consolidation. Depending upon the context, this has involved the formation of partnerships and cooperatives through to the merger and acquisition of hospitals, although the policy context within which this has occurred has varied.
- More recently, countries such as Australia and Ireland have been pursuing policies that mandate the formation of multi-hospital networks or groups.
- The organisation and governance of health care systems vary in the way health care services are organised and financed. In France, Germany and the United States, hospitals in the private sector, whether not-for-profit or for-profit contribute to delivering publicly funded healthcare care services, although the relative weight of their contribution varies.

Research: Hospital type by ownership

	Public hospital	Private not-for-profit hospital	Private for-profit hospital
France	• Comprise general hospitals and teaching hospitals • Owned by a local or national administration • Led by a director approved by the Prime Minister or the Ministry of Health	• Owned and managed by a private institution (association, religious organisation, foundation) • Public interest mission • Some centres dedicated to cancer care (teaching and research) • Provide publicly funded healthcare services	• Managed by private companies • No teaching or research mission • Provide publicly funded healthcare services
Germany	Operated under public law: • dependent (owner-operated municipal entity), or independent (public corporation) Operated under private law (e.g. limited company): • legal entity • administrative units (federal/ state/ regional/ local government) or social insurance hold > 50 % of the nominal capital or voting rights	• Operated and owned by church-based, charitable or welfare organisations • Provide publicly funded healthcare services	• Considered as business enterprises and require a licence under the industrial code • Provide publicly funded healthcare services

Research: Hospital type by ownership

	Public hospital	Private not-for-profit hospital	Private for-profit hospital
Ireland	• Includes hospitals owned by the Health Service Executive as well as voluntary hospitals • Voluntary hospitals are operated by a lay board of governors; funded primarily by government	Not defined	• Considered as business enterprises and require a licence under the industrial code
USA	Community hospital: accessible by the general public; defined as all non-federal, short-term general and other special hospitals (87% of all hospitals)		
	• State and local government: owned by state or federal government • Typically provide care to patients who would have limited access to care elsewhere • Have significantly higher proportion of patients who are uninsured or funded through Medicare or Medicaid	• Non-government not-for-profit: typically supported by a board of trustees • Charity status: does not pay state or local property tax or federal income taxes • Has to prove certain community benefits in accord with state and federal guidelines • Provide publicly funded healthcare services	• Investor-owned: owned by private investors or are publicly owned companies by shareholders in which case these companies can issue stocks to raise revenue for re-investment • Provide publicly funded healthcare services
England	• NHS trusts, directly accountable to the Department of Health • Foundation Trusts	• Generally referred to as 'independent' or 'private sector' • Considered as business enterprises and managed by private companies • Can provide publicly funded healthcare services but share is small	

Research Findings – RAND

There has been a trend towards the formation of hospital groups and networks

- There was a perception among key informants interviewed by RAND Europe that consolidation into health groups and systems will increase economies of scale while strengthening hospitals' position in the market and negotiating power.
- Consolidation may be encouraged by regulatory changes such as in the United States, where a requirement to have one staffing structure per hospital was recently removed. This means that hospital systems can now pool staff across hospitals in a system and this is thought to provide greater efficiency for the system.
- Other factors to be considered in the context of hospital consolidation include access to capital. This issue was raised in Germany, where it was noted that public hospitals would find it more challenging to raise capital compared to private (for-profit and not-for-profit) hospitals.
- France, Germany and the United States experienced an increase in the number of private-for-profit hospitals over the past two decades, with for example their proportion rising to one-fifth in the United States and one-third in Germany.
- There has also been a broader trend towards the creation of hospitals groups and multihospital networks in these three countries, with over 60 per cent of hospitals now part of some form of partnership, system or network as defined in the country.
- In Germany, an analysis of 65 large hospital enterprises or groups found that their market share rose from 25 per cent in 2005 to 31 per cent in 2011, and this growth was particularly pronounced among private for-profit hospitals.
- It is expected that this trend towards consolidation and the formation of hospital groups is likely to continue in these countries.
- It remains challenging to draw systematic comparison of different forms of hospital groups or systems within or across countries and the overall empirical evidence of the performance consequences of collaboration between healthcare providers remains weak.
- RAND Europe explored a small sample of large hospital groups or networks in France, Germany and the US and illustrated contrasting models based on hospital ownership.

Research Findings – RAND

	Public or private not-for-profit ownership	Private for-profit sector ownership
France	**Assistance Publique-Hôpitaux de Paris (AP-HP)**	**Générale de santé**
Features	37 hospitals (general hospital and other types of care facilities) Based in the Paris region 92,000 staff Provides 10% of hospital care in France	75 hospitals (general hospital and other types of care facilities) Presence across the country 23,500 staff Provides 16% of private hospital care in France
Mission	Public service mission including: • Delivering care to the Paris region population (from prevention and emergencies to highly specialised care) • Teaching and training (affiliation with medical schools and nursing schools • Research	Delivering high quality of care and efficiency
Origins and evolution	Medieval and catholic origins: the first hospitals were administered by nuns. Primary mission was to care for the poor and the terminally ill Secularisation in the 19th century. History of centre of excellence for medical innovation and research	Created in 1987 to diversify private hospital care supply Phase of expansion in the 1990's with international activities Listed on the stock market since 2001 Focus on France and on acute care activities in the late 2000's
Governance features	Governance structure defined by law Director appointed by government, supported in its role by a directory, and controlled by a surveillance commission Medical committee representing physicians to advise on strategy at the group and sub-group level Hospitals gathered in 12 sub-groups, with governance structure similar to group structure Five centralised services (procurement of non-medical goods and services, procurement of pharmaceuticals, laundry services, ambulance services, safety and maintenance services)	Owned by shareholders President and administrative board supported by audit and finance committees Medical committee representing physicians to advise on strategy at the group and hospital level Structure in hubs and network with some facilities within same geographical reach grouped into hubs
Financial turnover	€6.7 billion Deficit has been reduced in recent years, to reach -€20 million in 2012	€1.9 billion Group has recently sold mental health activities to focus on acute care and rehabilitation

Research Findings – RAND

	Public or private not-for-profit ownership	Private for-profit sector ownership
Germany	**AGAPLESION (2012)**	**Rhön-Klinikum AG (2013)**
Features	29 hospitals (6,400 beds), mostly providing general acute care with elements of tertiary care 31 nursing or residential homes (>3,000 places); assisted living/support (800) 3,460 medical and nursing staff (full-time equivalent) ~500,000 patients treated Ranked second-largest (by total bed count) private not-for-profit hospital group in 2012	54 hospitals (>15,000 beds) 41 medical care centres 2.6 million patients treated In 2013, the third largest private hospital group in Germany (as measured by bed count and financial turnover)
Mission	Values anchored in Christian faith, forming the basis for activities combined with excellence in medical and nursing care as well as responsible management AGAPLESION derived from Greek 'agapéseis tòn plesíon' (love thy neighbour) Driven by 6 core values: charity, respect, responsibility, transparency, professionalism, efficiency	Stated aim is to provide 'high-quality and affordable care close to home for everyone' Emphasis is on safeguarding autonomy in medical decision which the company interprets as a core condition for the delivery of high-quality care; interdisciplinary collaboration between doctors and nurses and the endorsement of integrated delivery models; and the promotion of innovation locally and across hospitals and external partners, drawing in particular on the research portfolio of its partner university hospitals
Origins and evolution	Founded in 2002 as non-profit joint stock company between Frankfurter Diakonie Kliniken (established in 1998) and 2 other hospitals in Heidelberg and Darmstadt Continues growth over time, most recently merger with a non-profit, charitable group, adding 5 hospitals, 4 nursing homes and medical care centres ('policlinics') (2012)	Has its origins in the take-over of operations of a spa and rehabilitation centre in Bad Neustadt an der Saale (the company's headquarters) by the company's founder in 1973 Move into acute hospital care from the 1980s Listed on stock market as first hospital group in Germany in 1989 Initially expanded through the establishment of new facilities but from mid-1990s also through acquisition of other hospitals, including (also for first time) of a university hospital (in 2006) In September 2013, take-over of 40 hospitals and 13 medical care centres by Helios-Kliniken authorised by the German competition authority; from 2014 downsized to five hospital sites with 5,000 beds and >15,000 staff

Research Findings – RAND

	Public or private not-for-profit ownership	Private for-profit sector ownership
Germany	AGAPLESION (2012)	Rhön-Klinikum AG (2013)
Governance features	Establishment as non-profit joint stock company motivated by desire to cooperate in order to grow Board of Trustees (18 members) which oversees management of the company Board of Directors manages the company Twenty shareholders Model of participation enables independence in local decision-making: newly integrated hospitals are acquired at a 60% share, permitting previous shareholders to retain strong position Integrated management structure	Converted from limited company to joint-stock company in 1988 States that good corporate governance was a 'high priority', which, alongside a 'transparent, legally flawless and ethical' culture formed the prerequisite for sustainable operations Governance model include management board, board of directors (20 members, chaired by the founder of the company), and seven standing committees (of which 5 with executive function), and advisory board to advise management board on trends in hospital care and medicine more broadly
Financial turnover	Registered capital (2012-13): €16.6 million, divided into ~332,600 shares (at €0.50 each) Investments of a total of €66.4 million in 2012 (of which 63% from own resources) Income hospital services (2012): €450.5 million; other areas: €120.5 million Total profits:€9.9 million	Turnover of €3 billion (a 5 per cent increase on 2012) Overall profit of €90 million (a loss of 2.6 per cent on 2012) Revenue generated from the provision of hospital services: €2,905 million; for medical care centres it was €58.5 million and for rehabilitation services it was €50 million

Research Findings – RAND

	Public or private not-for-profit ownership	Private for-profit sector ownership
United States	Intermountain Healthcare	Hospital Corporation of America
Features	22 hospitals, located in Utah and south-eastern Idaho 1,100 primary and secondary care physicians in >185 clinics (physician group) Owns and operates 6 community clinics and supports 12 further independent clinics	Owns & operates 159 general hospitals (>42,200 beds), operates 5 psychiatric hospitals (560 beds), operates 115 outpatient health care facilities in 20 USA states Provides approx. 4-5% of inpatient care in the US Some hospitals have affiliations with medical schools but do not typically engage in extensive research or teaching
Mission	Established in 1970 as a non-profit organisation to administer a 15-hospital system donated to the community by Church of Jesus Christ of Latter-day Saints Evolved into multi-hospital system by 1985 but with little integration across Reorganisation from 1985 geographically and administratively System integration from 1992	Formed in 1968 as a hospital management company by three physicians in Nashville Expanded through acquiring facilities and building new hospitals and contracting to manage hospitals for other owners Rapid growth, from 26 hospitals and 3,000 beds by end of 1969 to 349 hospitals with >49,000 beds in 1981 Period of consolidation during the 1980s; emerged as a public company in 1992, followed by ongoing re-structuring In 2006 acquired by a private investor group and became a private company (for the third time) but reverted back to publicly traded company in 2011
Origins and evolution	'A mission of excellence in the provision of healthcare services to communities in the Intermountain region' Commitment to provide care to those who live in the Intermountain region who have a medical need, regardless of ability to pay	Commitment to 'the care and improvement of human life and strives to deliver high quality, cost effective health care in the communities we serve' HCA Code of Conduct provides guidance on carrying out daily activities within appropriate ethical and legal standards

Research Findings – RAND

	Public or private not-for-profit ownership	Private for-profit sector ownership
United States	**Intermountain Healthcare**	**Hospital Corporation of America**
Governance features	Central executive leadership (CEO, COO, CFO, CSO) Organised at regional level with similar executive committee structure Officers and leaders from regions and divisions involved in system-wide decision-making Central Board of Trustees oversees operation	Owns and operates some of its healthcare facilities while also operating facilities on behalf of other owners Provides resource and support to its facilities but management decisions are taken locally Corporate governance involves a central Board of Directors & Officers and a number of committees which serve to assist the Board of Directors in fulfilling its responsibilities (eg: Audit & Compliance Committee, Compensation Committee, Nominating & Corporate Governance Committee, Patient Safety & Quality of Care Committee)
Financial turnover	As Intermountain Healthcare is open to patients not enrolled with its own health plan (SelectHealth); payment for patient services comes through a range of sources including Medicare and Medicaid In 2012, total funds available compensated for total funds used (USD4,919 million) Non-profit status means that the organisation needs to spend on charity care more than they would have otherwise paid in taxes Usually targets a margin of 3% to allow for reinvestment into infrastructure and services	HCA receive payment for patient services through Medicare, Medicaid or similar programmes, managed care plans, private insurers and directly from patients In 2013 the largest source of revenue was from managed care and other insurers (54.6%) with Medicare as the next largest source (23.3%) Total revenues for 2013 after provision for bad debt were USD34,182 million against outgoings of USD31,236 million resulting in a net income of USD1,966 million

Research Findings – RAND

The empirical evidence on the nature of cooperative arrangements between hospitals and impact on performance remains scarce

- In France, Germany and the United States, consolidation has typically, although not always, involved privatisation, and this was driven by a combination of factors with the competitive environment, in terms of capacity and economic pressures , being seen to be amongst the main drivers.
- This contrasts with the experience in the English NHS, where consolidation of the public hospital market in the late 1990s and early 2000s was largely achieved through a merger of public hospitals that were co-located geographically.
- Analysis of public hospital mergers in England during the late 1990s through to the mid-2000s points to a limited impact on outcomes such as financial performance, productivity or clinical quality, with the only exception being a reduction in activity.
- While this lack of success can be explained, at least in part, by failure to take account of the complexity involved in organisational change at scale, it highlights the importance of context and the drivers of change behind mergers as important contributors.
- The empirical evidence on the impacts of hospital mergers on outcomes such as technical and cost efficiency has remained inconclusive.
- The vast majority of studies originate from the United States, with some suggestion of positive impacts of hospital mergers on technical efficiency and cost efficiency, while other evidence points to potentially negative effects on patient outcomes.

Research Findings – RAND

The evidence of the effects of hospital consolidation is not clear-cut

- The majority of empirical studies focus on the impacts of hospital mergers, whilst less is known about the potential differential impacts of different forms of hospital consolidation that involve the formation of, for example, hospital groups or systems.
- There is limited evidence suggesting that different forms of hospital cooperation, such as hospital groups, networks or systems, may have different impacts on hospital performance.
- The evidence available seems to support the notion that the performance of inter-hospital cooperation will be dependent on the nature of the cooperative arrangement in place. Hospital groups or systems that are owned and managed by a single legal entity may be more successful in achieving efficiency gains and improvements in the quality of care than hospital networks that are formed through strategic alliance or contract agreement but this is likely to depend on the context within which the different formations operate.
- Whilst hospital consolidation may lead to quality improvements there are also some risks and it will be important to monitor the effects of consolidation to protect the public from unintended consequences.
- Hospital consolidation may lead to quality improvements as increased size allows for more costly investments and the spreading of investment risk. Also there is evidence that a higher volume of certain services such as surgical procedures is associated with better quality of care.
- However, the association between size and efficiency is not clear-cut and there is a need to balance ‘quality risk’ associated with low volumes and ‘access risk’ associated with the closure of services at the local level.
- Benefits may be achieved through shared services with other hospitals, in recognition that economies of scale can be achieved through reducing the duplication of back office services and through the concentration of purchasing power.
- However, the services to be shared across hospitals may have to be carefully selected as other evidence suggests that shared management and shared clinical workforce across hospitals may lead to poorer performance or inefficient use of resources

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Case study findings

The international visit programme gathered first-hand qualitative evidence on how hospital group/chain providers operate and found there are similar processes and practices they adhere to

- There is a level of central control in a hospital group/chain structure and key roles including strategy, investment, recruitment, performance standards and monitoring are directed through the centre.
- Each organisation has created and set a clear vision and mission statement that they strive to deliver and expect operating units to follow.
- Stewardship of the organisational brand and communications are viewed as a corporate function.
- All providers have made significant investment in IT and electronic records which allows them to monitor performance stringently and set performance standards and metrics.
- There is a clear focus on setting high benchmarks for performance and quality, with some providers benchmarking their own performance against the best performing hospitals around the world.
- Procurement is almost exclusively carried out centrally, on the basis this generates the greatest economies of scale. Every hospital visited managed to leverage considerable economies of scale on procurement, with some providers managing to make up to 20% savings in new hospitals that had joined the group.
- Most chain providers have established panels comprising of senior professional/clinician staff from across different sites to input into decisions and identify the best practices and products/prostheses.
- All chain providers have clearly defined processes for capturing, testing and dispersing innovative practices.

Case study

AMEOS, Germany/Austria

- AMEOS was founded in 2002 and has grown to become one of the major private, for-profit hospital groups in German speaking countries.
- The group is headquartered in Zurich with the majority of its facilities located in Germany and a small number in Austria.
- Its business model is to acquire failing hospitals and invest in their facilities and services to provide long term value.
- The group owns and operates 68 facilities (47 hospitals and 21 long term care) providing acute, mental health and long term care services in 36 locations, with approximately 12,000 employees and 8,000 beds.

Key Learning:

- AMEOS aim for up to 20% savings on procurement when sites are taken over, as well as more efficient methodologies. Their chain structure enables them to more easily facilitate the spread of best practice.
- When integrating new facilities into the group, one of the most important roles is the 'integration coach' – who helps with human and cultural integration.

Governance and accountability

- The group is divided into four regions (Saxony-Anhalt, North, Lower-Saxony and South) which mirror the structure of the central office to provide support hubs for the facilities in each region.
- The Zurich head office hosts a number of back office and support services, including performance and process development, IT, purchasing and HR.
- Zurich head office is also responsible for strategy and support services, with the regional hubs held accountable for their overall performance.

Performance Management

- Each hospital is run with minimal management overheads (c. 5-6 managers per site) as they are supported by their regional hubs, where back office and support functions are concentrated to provide economies of scale.
- Standardised performance indicators which follow international patient safety goals.
- Benchmark against international standards for infection control and patient safety.

Case study

AMEOS, Germany/Austria

Culture and Values

- AMEOS uses a tripartite approach to integrating new acquisitions, with significant input from head office and the regional hub, complemented by 'integration coaches'.
- This 'integration coach' is typically an experienced AMEOS employee, who works elsewhere in the chain, who buddies with people in similar roles at the new hospital.
- They proffer a 'Once AMEOS, always AMEOS' philosophy, emphasising the long term nature of their acquisitions.
- Staff magazine and intranet part of a consistent branding exercise in all facilities, both old and new.

Barriers

- Professionals seek to work in metropolitan areas (AMEOS is largely based in non-metropolitan areas) and thus recruitment has sometimes been an issue.
- Navigating state government service specifications for each hospital and working to change some of these.

Infrastructure and Central Services

- AMEOS aims to acquire 100% of potential hospitals.
- Where public hospitals own a large amount of surplus land or other assets not required, they are disposed of before the sale of the hospital.
- AMEOS have developed process improvement methodologies to improve average length of stay and operating theatre utilisation in order to ensure it makes best use of existing facilities before investing in additional capital.

Efficiency and standardisation

- The group does not utilise as much standardisation of systems and processes as other hospital chains, but is clear about what is a 'must do', and where there is scope for local variation.
- They do, however, use standardised pathways in a number of areas and are looking to expand this in the future.
- Pay and reward is linked to performance so 10-25% of consultants' salary is a performance bonus.
- Savings from procurement and group improvement methodologies.

Case study

Apollo Hospitals, India

- Apollo Hospitals is one of the largest private, for-profit integrated healthcare groups in India.
- They have over 30 years experience in setting up hospitals across India and the world.
- Apollo has 54 hospital locations, with over 9,000 beds and more than 75,000 employees.
- Delivers high quality tertiary care and owns and operates clinics, diagnostic centres, pharmacies (1,600) and provides healthcare management consultancy.
- Focuses on greenfield investments – building new hospitals – and is expanding further into what is a very under-developed national market.

Key Learning:

- Performance and quality benchmarking, taken from world's best institutions, drives excellence in clinical practice.
- Strong focus on clinical leadership in setting best practice and driving standards.

Governance and Accountability

- The group is governed by a Chairman and board of directors.
- 4 regional CEOs, covering the North, East, Central and South India.
- Each hospital has a CEO and a medical head. A quarter of each CEO and medical head's appraisal is related to outcomes.

Performance Management

- A clinical balance scorecard – 25 clinical quality parameters including complication rates, mortality rates, one year survival rates and average length of stay after major procedure. Also includes hospital acquired infection rates, pain satisfaction and medication errors.
- 6 centres of excellence – heart, orthopaedics, neurosciences, transplant, oncology and emergency medicine. Busiest solid organ transplant program in the world with more than 1400 transplants (liver and kidney) in 2013
- Parameters are benchmarked against the published benchmarks of the world's best hospitals including Cleveland Clinic, and Mayo Clinic.

Case study

Apollo Hospitals, India

Culture and Values

- Significant emphasis on bottom-up innovation and have ‘ideas boxes’ in every site for all staff to contribute to.
- Established own schools and colleges of nursing.
- Established own institutions to train managers.
- Founded an Institute of Medical Sciences and Research.
- ‘ACE forum’ for clinicians. Harnessing social media to improve clinical culture, encourage joint working and facilitate telemedicine.

Infrastructure and Central Services

- Developed state of the art healthcare infrastructure.
- Invested in latest technology and expanding telemedicine.
- HR: Centralised initiatives for staff recruitment, retention and staff satisfaction; centralised induction and training.
- Finance: cost control functions and the ability to absorb initial losses during gestation period of new hospital.
- Procurement and central purchase.

Barriers

- Challenges in standardisation as every region has a unique set of circumstances – such as variance in demographics, disease profiles, patient attitudes.
- Handling complexity requires rigorous management overview, for sustaining clinical standards.
- Building a uniform culture as they operate over diverse geographies with different cultures and different leadership styles.

Efficiency and Standardisation

- Medical services: standardisation of patient safety processes and clinical outcomes.
- Clinician engagement and sharing best practice.
- 20 auditors at central level to manage and analyse group data.
- Nursing Services: standardisation of nursing processes and sharing of resources.
- Cost efficiencies through sharing of managerial and clinical resources.
- Economies of scale for negotiation in central purchasing.

Case study

Cleveland Clinic, US

- The Cleveland Clinic (CC) has become one of the top performing private healthcare systems in the US over the last 5 years.
- It started as one academic medical centre. Over 25 years they have acquired 9 Community hospitals in the Ohio area.
- Out-of-state ventures are seen as revenue opportunities, and other partnerships established when there has been an opportunity. CC hospitals established in Florida and Abu Dhabi.
- The structure has grown organically, but CC are now becoming more strategic and seeking to actively build formal partnerships.

Key Learning:

- Beyond the direct ownership model, CC have created a number of different relationships with organisations across the US including consulting relationships (advisory); service agreements; affiliations; operating agreements; mergers; acquisitions.
- The organisation is open and transparent with its performance metrics which have led to strong practices and an exemplar to other international organisations.

Governance and Accountability

- The CEO is the overall head of the entire organisation and is supported by an executive team.
- Each community hospital has its own board, in most cases are legacy from pre-acquisition.
- Each board is headed by a board president and the board presidents of all the regional hospitals make up an overall regional board.
- Set up a Clinical Enterprise Management Board that provides clinical advice to the CEO.
- There are 21 clinical institutes.

Performance Management

- Patient experience is scored and shared across the whole CC network, and where possible with the partner/shared organisations. These scores are reported every 90 days.
- The scorecard covers quality, finances, patient safety and patient experience over 18 months.
- The data on patient experience is listed by named physician and is made public so the patient experience scores of every physician in all of the hospitals (measured by HCAHPS) is transparent and can be compared.

Case study

Cleveland Clinic, US

Culture and Values

- The most important cultural value is patient experience.
- Shared culture and values are very important for creating a sense of a single system.
- Visible leadership helps in establishing common culture.
- Visual reminders including same logo, uniform etc. is seen as helping to create the expectation of a unified culture.
- Compulsory day of training for every member of staff.

Infrastructure and Central Services

- A key component is the Electronic Health Record which is shared across every member organisation and must be fully compatible across CC.
- Capital strategy, budgets and driving efficiencies programme are driven by the centre.

Barriers

- Difficult to overcome local culture and trying to forcefully import own culture alienates partners.
- Creating a shared culture across all organisations is a significant challenge.
- Some potential new hospitals who might have joined the group have been put off by the requirements for standardisation.

Efficiency and Standardisation

- CC have delivered cost savings through reorganisation, benefiting the group rather than individual hospitals.
- The main source of standardisation is clinical pathways developed by the Institutes.
- Standardise best care practices across all hospitals.
- Rationalised procurement.

Case study

Générale de Santé, France

- Générale de Santé (GDS) is the major private, for profit hospital group in France.
- GDS has 75 clinics, and 19,000 employees.
- They have set up 19 clusters (poles) to structure and coordinate care pathway at a health territory level.
- More than 95% of GDS clinics are in what they define as attractive quartiles based on demography, population, location – university in close proximity.
- GDS have 13% of private market share; with 32% of market share in the health territories they cover.
- GDS have achieved growth through acquisition.

Key Learning:

- Générale de Santé are at an early stage in their journey of standardisation. They have made good progress and are beginning to reap the benefits from rationalising corporate functions.
- The organisation acknowledges there is more scope to standardise practices and reap further benefits.

Governance and Accountability

- A staff of 200 at HQ drive the group strategy and operations.
- 19 clusters that conduct growth strategy and healthcare provision.
- The cluster manager reports financial accounting and plans to HQ every 3 months.
- Individual operating sites are accountable.

Performance Management

- Performance targets are set at individual hospital site level.
- 58% of its establishments are certified, more than twice its competitors, and higher than the national average.
- They have developed a 'net promoter score' (NPS) by patients, which is closely monitored.
- Medical outcomes and the NPS are the key drivers of management values.

Case study

Générale de Santé, France

Culture and Values

- GDS has a vision of care excellence and to 'become ***the*** healthcare provider of preference'.
- Part of GDS value proposition is a 'patient-centric approach' and they have created a marketing and patient relationship department.
- They developed a talent management initiative to secure physicians and mitigate risks of retirements.

Infrastructure and Central Services

- Recruitment, finance and purchasing managed centrally.
- Investment decisions (Capex) centralised.
- Developed an information system database which has all suppliers and prices.
- Investment in digital technology.

Barriers

- Main barriers are political.
- In private sector you have to 'transform or die' and that impetus is not the same in the public sector.

Efficiency and Standardisation

- They are early in their journey of standardisation and they have started with non-clinical procurement.
- Focused on procurement optimisation and aiming for 2% savings on 2012 baseline.
- Set up an e-sourcing and e-auction platform.

Case study

HCA, US

- HCA (Hospital Corporation of America) is the largest private, for profit healthcare provider in the world and provides 5% of all the healthcare delivered in the US.
- HCA have 167 hospitals and 120 outpatient centres in 42 geographical areas in 20 states across the US.
- The HCA model has traditionally been to take on hospitals, keep them as unchanged as possible at the front end so that change is invisible to patients, and streamline the back office functions.
- They have developed a subsidiary company called Parallon, which provides back-office functions to the private and public market.
- HCA has a presence in the UK, concentrated almost entirely in London and Manchester.

Key Learning:

- HCA have driven rationalisation of back office functions (nearly $3bn of savings over 5 years) through standardising and then moving back office functions out of individual providers to division level.
- Created effective datasets from their 23m patients across 167 hospitals which has enormous potential for quality and outcome improvement to be fully realised.

Governance and Accountability

- The organisation as a whole is divided into two groups. Within these two groups there are a total of 7 ‘divisions’ each of which covers 8-17 hospitals, and a number of other outpatient organisations and support services.
- The CEO is based in the Nashville offices and is supported by an executive team.
- There is a similar structure at group level, divisional level, and individual facility level.

Performance Management

- Using data from across their entire organisation to benchmark performance and identify outliers. The centre works with groups of physicians to develop what essentially amount to clinical pathways and best practice guidelines.

Case study

HCA, US

Culture and Values

- The organisational strapline is ‘committed to the care and improvement of human life’.
- HCA try to retain as much of the original culture of acquired organisations as possible in order to retain existing community links.

Infrastructure and Central Services

- The single most important part of their infrastructure is a standardised Electronic Medical Records which allows them to collect standardised data on 23 million patients a year.
- The depth of hospital management experience at every level of the organisation (in hospitals, in divisions, in central head office) and the clear roles and responsibilities of individuals working at each of these levels.

Barriers

- Challenges with corporate identity and have found that physicians tend to distrust a heavily corporate organisation.
- Face 20 different regulatory regimes across 20 states. They have generally taken an approach of complying with the most stringent set of regulations.
- Standardisation is challenging as it takes a long time to make changes.

Efficiency and Standardisation

- The most important part of creating efficiencies has been through streamlining and standardising back office functions through 14 consolidated distribution centres and 7 consolidated supply centres from the early 2000’s.
- Economies of scale particularly from standardisation of procurement, and acquiring supplies at a cheaper price.
- The standardisation in clinical practice occurred much more recently from about 2009.

Case study

Humanitas, Italy

- Humanitas are one of Italy's most successful private, for-profit hospital groups.
- There are 6 hospitals in the group – 5 of which are Joint Commission International (JCI) accredited. These are based in Lombardy, Piemonte and Catania.
- In 2014 they opened Humanitas University in association with the University of Milan. They are one of the top 6 research institutions worldwide.
- Humanitas run a hub and spoke model. Their largest hospital, Istituto Clinico in Rozzano, is the hub.
- The contiguity of 5 of their hospitals in Northern Italy is an important enabling factor in the model – as it has facilitated joint projects, allowed them to easily share clinical resources and facilitated the development of cross-hospital patient care

Key Learning:

- Humanitas drive and maintain excellent clinical standards by stressing the importance of research and teaching in their organisation. They argue that this both attracts clinicians and keeps them at the top of their field once there.
- Their model has allowed them to develop strong care pathways across different locations. Each hospital does not provide every service – but patients still experience joined-up care in an efficient way.

Governance and Accountability

- Humanitas comprises 2.5% of its parent multi-national industrial group, Techint. They are financially and operationally separate from it.
- The CEO of each hospital is accountable for the performance and activities of each hospitals.
- Humanitas is governed by a central holding group, which consists of c16 employees.
- Each hospital does not sit on the board of the holding group. Instead, the vice-president sits on each hospital's board.

Performance Management

- The holding group are very operational and are given a 25 page group dashboard report every morning at 9am.
- Reporting on performance takes place at a central level, with hospital CEOs reporting monthly to the group CEO and CFO on 5 main areas: clinical quality, economics, production and inefficiency KPIs, action plans, and HR.
- Consistent benchmarking across the group to allow each hospital to see the performance of the others.

Case study

Humanitas, Italy

Culture and Values

- Humanitas believe it is possible to apply methods and processes to healthcare similar to their industrial parent company, Techint.
- Each hospital is recognised as being different – and that the same service cannot be provided in every hospital due to the unique health economy demands of each location.
- Clinicians are attracted by Humanitas' research and education programmes. Humanitas believe that without this it is very hard to do clinical activity *excellently*.

Barriers

- Face challenges bringing their only site not in Northern Italy (Sicily) into the group.
- The main lesson they have learned is that the further the site is from the hub, the greater the level of operational freedom the hospital tends to have.
- Renewing old hospitals was a challenge in a number of institutions.

Infrastructure and Central Services

- The group separates the property company from the operating company. The operating company rents the buildings from the property company, which provides the freedom to move and rationalise estates more easily.
- Humanitas University, in association with the University of Milan, opened in 2014.
- The group structure enables large investment in new technology. 6% of their margin is reinvested in this.

Efficiency and Standardisation

- Leverage efficiencies by keeping certain processes within the holding group, conducted on a group-wide basis: Procurement, IT, Quality Programmes and Management.
- Procurement is the second biggest cost in the group after people and they have managed to reduce this expenditure by purchasing 80% at group level and 20% locally.
- Standardise quality standards, economic data and real estate, with a very flexible approach to buildings. 40% of Rozzano site has been redesigned over its lifespan.

Case study

IHH Healthcare Berhad, Singapore

- IHH (IHH Healthcare Berhad) is a leading international private, for-profit provider of healthcare services throughout the world, although the group's three key markets are Turkey, Singapore and Malaysia.
- 37 hospitals, with 6,000 beds and over 25,000 employees.
- IHH offer a comprehensive suite of services – complementary ancillary services, primary, secondary , tertiary and quaternary services.

Key Learning:

- Their meticulous approach to acquisition, focused around thorough due diligence pre-acquisition and complement the new hospital's senior leadership team post-acquisition. This helps to fully engender assimilation to the group.
- Standardised performance indicators that follow International Patient Safety goals are used to drive operations and benchmark performance. This data is updated in near-time, tracking both lead and lag indicators, so that performance across the group can be closely monitored and managed.

Governance and Accountability

- Each hospital has a medical advisory board which determines operational and clinical compliance.
- Corporate functions are guided by IHH Corporate Governance and Industry regulations.
- CEOs of hospitals report to respective country heads.
- When a new site is acquired, IHH put their teams – including their own COO, CFO and Director of Nursing – into the new hospital for 3-5 years so as to fully support assimilation.
- Senior group management chairs quality forums and improvement opportunities.

Performance Management

- Balance scorecard with 5 pillars – people, quality, finance, service and growth.
- Standardised performance indicators which follow International patient safety goals.
- There is a Central Quality Forum which meets every month to monitor performance across the group.
- They receive near-time information on performance regularly in order to best manage the group.
- Hospital CEO's receive performance related pay, based on key performance indicators.

Case study

IHH Healthcare Berhad, Singapore

Culture and Values

- Senior Operational Management drives HR practices, talent training and development, infrastructure, system and processes.
- Many professional and career development opportunities as group grows.
- 5 'I's to drive value creation: Imagination, Integration, Initiation, Implementation, Innovation.
- Innovation driven at a corporate level but encourage localisation to better meet business needs operationally.

Infrastructure and Central Services

- Cutting edge technology via centres of excellence.
- Service standards and training support.
- Developed IT systems for near-time information.
- Group resources enables investment into processes, technologies and human capital.

Barriers

- Having to confront a knowledge and talent mismatch across geographies.
- Navigate barriers with different market entry models, from full ownership in home markets to joint ventures in some overseas markets.
- Language barriers across their three main markets of Turkey, Singapore and Malaysia.

Efficiency and Standardisation

- Standards and protocols have led to efficiency gains in terms of tested processes and standards.
- Procurement and sourcing.
- Discipline for commercial sustainability eliminates wasteful processes and create mind set for innovation an improvement.
- IHH stress the importance of conducting rigorous due diligence before acquiring new sites – and identify this as a critical success factor for acquisitions to date.

Case study

Ribera Salud, Valencia, Spain

- Ribera Salud Grupo was established in 1997 to design, build and operate a new hospital in La Ribera, Valencia Community under a public-private integrated partnership (PPIP).
- The Ribera Hospital was the first privately run public hospital in Spain, expanding into primary health services shortly afterwards.
- The model has since expanded across Valencia and in other regions in Spain: 4% of the Spanish population is now treated under PPIP models, and 20% of Valencia's population.

Key Learning:

- The capitated funding model and a "money follows the patient" approach allows for defined public expenditure while encouraging quality and efficiency from the provider.
- The model is enabled and driven by comprehensive, real time data for management, clinicians and patients to make optimal use of resources.

Governance and Accountability

- Ribera Salud operates the concession under contract with the government, which holds them to account – through a commissioner- for quality standards and outcomes.
- Ribera Salud assumes the risk for demand and outcomes over the 15 year duration of the contract (extendable to 20).
- Each hospital is a separate company, with Ribera Salud the majority shareholder in two of these. There are separate governance and accountability structures in each hospital.

Performance Management

- Variable salary for clinical staff dependent on performance; incentives to actively manage demand and consider wider system aims.
- Strong focus on decreasing clinical variability. Performance metrics are intensively monitored and variation addressed.
- 20% of staff are directly employed by the local government and cannot be paid the same performance based salary, but these staff are incentivised with training and career pathways.

Case study

Ribera Salud, Valencia, Spain

Culture and Values

- The objective of the capitated payment system is “to achieve the best health conditions for the citizen”.
- Their business model is to keep all inhabitants within the concession loyal to the organisation, and to keep the population as healthy as possible. Both these are financially rewarded under the contract.
- No company logos – only the national health service branding as in any other public hospital. 94% of patients do not know the hospital is PPIP operated.

Barriers

- The last few years – in difficult wider economic circumstances – have been challenging, as the government is the sole client of the organisation.
- Implementing the capitated model and aligning the private and public objectives was extremely challenging.
- Requires a new approach of partnership and a long term perspective. There is no short term profit or savings to be made.

Infrastructure and Central Services

- Ribera Salud financed and built the site, which returned to public ownership after 10 years. They now pay rent to the government for its use.
- The IT and data systems works across all the sites in the group, providing highly granular data and real time performance feedback.

Efficiency and Standardisation

- There is a strong focus on rationalising shared services, with a single lab across all Ribera Salud sites.
- Workforce and expertise is shared between sites in the system, with the same clinicians working in emergency and primary care sites.

Case study

ZNA, Antwerp, Belgium

- ZNA is a private, not-for-profit hospital group in Antwerp, Belgium.
- It has 9 hospitals – 3 acute and 6 specialised.
- It took over the hospitals in 2004 from the City of Antwerp when they were in a dire financial situation. A not-for-profit organisation as a partnership between the doctors and a newly created corporate entity was established as a new entity – ZNA.
- The first five years of the organisation were focussed on making near bankrupt hospital organisations viable again.

Key Learning:

- Centralising back office functions at the outset delivered the group significant cost savings.
- The chain structure also allows them to spread best practice and innovation across the group.
- It is important to have effective systems of communication between group and site level.

Governance and Accountability

- The board is comprised of 14 people, all from different professional backgrounds, including legal, engineering and political. They have strategic, decision-making responsibility.
- There is a Hospital Group Executive Team and a leadership team for each individual hospital, comprising a team of three people (chief physician, head nurse and operational director).
- Local hospital leaders have operational decision-making power. This power has been increasingly devolved as the group's financial situation has improved.

Performance Management

- ZNA sees leadership as critical and when ZNA took over its hospitals, everyone had to reapply for their roles and not everyone was successful but they believe they have a stronger leadership team as a result.
- ZNA has a 5 day clinical leadership programme to build leadership ability amongst its clinical teams.
- They use financial incentives for senior management and some local hospital management as well. Part of the salary is set as variable, where the variable section is dependent on certain key financial and other metrics, such as quality and service.

Case study

ZNA, Antwerp, Belgium

Culture and Values

- ZNA have experienced some difficulty in getting people to identify with the group as opposed to the local hospital and the competitive legacy between hospitals is still there.
- ZNA still sometimes perceived as the conqueror by staff at hospitals which they have acquired. They are working hard to alter this perception.
- Emphasis on the pride associated with being a part of a turn-around project.

Infrastructure and Central Services

- Their contract with the government states that, since their takeover, everything built from 2004 belongs to ZNA.
- As such, ZNA is now building a new hospital and plans to decommission two older hospitals.
- For these two older hospitals, the government owns the land and assets and rents the site to the group.

Barriers

- ZNA do not believe that their model would work well across larger geographical distances because of the way in which they share clinical resources.
- Site level issues take longer to sort because of the lack of an effective path of communication between hospital and group.
- Integrating different legacy systems (such as IT and back office) can be technically challenging for the new network.
- Building a unified culture gets more difficult with distance.
- Have had difficulties in sharing staff between sites because of clinical resistance to the extra demands it makes.

Efficiency and Standardisation

- Centralisation of back office delivered significant savings. Modernising and centralising these functions was estimated to deliver almost 1/5th of the deficit in savings.
- ZNA learn from the best practices of other hospitals in the network and spread it across the group.
- Overarching executive management ensured that there is more emphasis on the same procedures being used across the network.
- Discipline for commercial sustainability eliminates wasteful processes and create mind set for innovation an improvement.

Department of Health

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