



The Insight Papers: Management series

The five R's for NHS mergers and integration

A reflection on best practice



Introduction

NHS acute providers face an uncertain future, not least the financial constraints resulting direct from the 'Nicholson Challenge' - a call to the entire NHS to find £20 billion of efficiency savings by 2013/14. The pressure to find these savings is being felt most in the acute sector where there is speculation that around 20 hospital trusts are in financial meltdown.

Since the first NHS foundation trusts were created in 2004 there are today (September 2012), 144 NHS trusts that have been granted foundation status. The government has made it clear that the majority of the remaining NHS trusts will have to attain foundation status by April 2014. It believes NHS hospitals should run their own affairs and be accountable to local people and patients, as opposed to being subject to top-down direction from the Department of Health.

However, becoming a foundation trust places certain requirements on aspiring hospital trusts and some would argue the bar has been raised in recent years. Amongst these requirements are: strong governance, long-term financial viability and a framework to secure delivery of quality services. It is likely a significant number of the remaining NHS trusts are not going to meet this target

date and this is creating uncertainty about their future.

In addition, the foundation trust process itself is often cited as a reason for creating further stress among providers. Sue Slipman, ex-Chief Executive of the Foundation Trust Network and contributor at the recent Allocate Software Executive Advisory Board session on NHS mergers and integration, believes the pipeline for foundation status is already creating pressure within the system. "The foundation trust pipeline is a driver for service reconfiguration," she says. "The pressure on trusts is inescapable and even if we put the brakes on, this in itself will cause problems."

Service reconfiguration could happen in a number of ways either through merger, acquisition, partnership or alliances. It can be vertical (from acute sector through to primary and community care) or horizontal (within the acute sector). This report is not intended to be a management guide for each of these scenarios but rather a reflection on what factors need to be considered by those organisations on the brink of change.

"It's impossible for us to achieve the changes we are talking about without there being changes in the capacity of acute hospitals and the configuration of acute hospitals. Whether there are fewer in total is a moot point."

**Andrew Lansley,
Former Secretary of State for Health,
2011**



Executive Summary

A Whether it is a result of coercion or design, provider organisations in many areas of the country are now being faced with merger, acquisition or some other form of partnership or alliance.

There is plenty of evidence from the private sector that merger and acquisition presents significant challenges. Widely-quoted figures suggest that up to 80 per cent of mergers and acquisitions fail to deliver shareholder value. For shareholder value read improvement in the quality of services provided to patients, so merger and acquisition within the NHS has the potential, if poorly executed, to be very damaging to the services that are provided to patients.

With insight and guidance from members of the Allocate Executive Advisory Board we have summarised five key areas of focus for organisations that are considering organisational change. We have called these the 5Rs of reorganisation: Reasons; Resources; Rules; Rhetoric and Risk.

A **Reasons.** When considering any reorganisation there has to be a clear set of reasons for making the change. This includes developing a rationale to show strategic objectives will be met as well as compiling evidence that patients experience and outcomes will improve.

A **Resources.** Sufficient human resources have to be committed to ensure the success of the project and they have to be committed for the long-term. Successful mergers and acquisitions take years to achieve.

A **Rules.** Any organisation seeking to take or merge with another has to abide by the rules that are in place to ensure standards of care are maintained. With the regulatory body Monitor now responsible not only for granting foundation status but also for economic regulation its remit has widened to cover competition and continuity of service. Furthermore with the Care Quality Commission increasing inspections organisations need to ensure that all parts of the newly formed organisation are abiding by the rules required to maintain the licence to operate.

A **Rhetoric.** When change is afoot within the NHS, rhetoric is never far away, yet it often fails to explain why a particular course of action has been chosen. Making sure patients, public and staff understand why something is being proposed and helping them to make their views count is critical to success.

A **Risk.** Finally risk is one element of change that has to be explored, understood and managed within the constraints of the trust's appetite for risk. Risk needs to be considered in terms of the risk of failure and the risk to the organisation of undertaking a given course of action.

Focusing on these five areas will increase the likelihood of a successful reorganisation that meets strategic objectives and ultimately delivers significant quality improvement.

1. Reasons

The Government has accepted that some hospital trusts will not attain foundation status and it is also clear that, as the financial pressure increases, some district general hospitals will become unviable as they are presently configured. The question is then what happens to these trusts. It has been suggested that top performing foundation trusts, or private sector providers will be encouraged to intervene. Hinchingsbrooke, which was taken over by Circle, looms large in NHS consciousness. This is the first time the running of a state-funded hospital has been outsourced to the private sector. However, even foundation trusts could have a question mark over them especially where they breach Monitor's terms of operations.

This forced approach to service reconfiguration is far from ideal. A better starting point is a merger or acquisition driven by strategic necessity. Yet we are already seeing instances where some foundation trusts are being primed to merge or acquire smaller hospitals. Even where this is the case the fundamental question 'why' still needs to be asked. Duncan Astill, contributor at the Allocate Executive Advisory Board and Associate, Mills & Reeve LLP, says: "Having a clear rationale for why you are doing it is vital, and where you have successful organisations taking over failing organisations the question that needs to be addressed is 'how are we going to deal with the underlying problems'. Often these problems are multifactorial and this will mean changing the way the organisation operates. With district general hospitals for example, it may be more appropriate to consider delivering a wider range of community services."



Key Point

In making the case for horizontal or vertical integration, trusts will have to produce clinical evidence for the CCP that points to improvements in quality of care. This clinical evidence can, and should, form the backbone of the vision that will need to be used to engage all stakeholders.

"The danger is that the larger trusts will want to take over and be responsible for providing services from regional trauma centres through to services that are closer to patients. Controlling the entire pathway gives you the advantage and because of the current payment system it is akin to printing your own money."

Equally important is whether the change will improve the quality of services provided to patients. However, this can quickly become mired in debate and discussion on how the benefits are best measured. Witness the merger of Barts and the London NHS Trust (BLT), Newham University Hospital NHS Trust (NUHT) and Whipps Cross University Hospital NHS Trust (WCUHT). Here the Competition and Cooperation Panel (CCP) published a report on the same day that NHS London approved the business case. The CCP's report was critical of the move saying it would reduce competition and choice for patients receiving elective and non-elective care in Newham.



There is no doubt the CCP will play an increasingly important role in NHS reconfiguration and it is obvious that the panel expects precise detail from trusts about who will benefit and how these benefits will be achieved. There have been numerous occasions where the CCP response to reconfiguration has been that the parties did not provide any detail at all. So the message is clear, not only does there have to be a strategic fit but success, not just where the regulatory regime is concerned, will depend on hard evidence particularly around the clinical benefits.

Trusts that want to make the case for horizontal or vertical integration (whether through merger, acquisition or any other means) have to produce clinical evidence showing there will be improvements in quality of care.

David Foster, member of the Allocate Executive Advisory Board and Director of Nursing, Department of Health, believes the struggle to produce this clinical evidence leads many organisations to consider structural reorganisation in individual service areas. "Lack of evidence makes it easier to do it service by service rather than tackling it on an organisational level," he says.

He believes the requirement to gather evidence will be a challenge for commissioners: "They have to commission on an evidence base but often have to resort to proxy outcomes. This is all very well when you look at outcomes for surgery, for example. The big question is how this plays out in terms of the frail elderly with complex conditions where an intervention could lead to a series of complications and cause readmission for a series of other problems that have occurred."

"This issue of growing complexity is a real challenge for any commissioner and provider of healthcare. The sad truth is that workforce planning has really not kept pace with it."

This focus on evidence through measurement is therefore crucial. For example, evidence based on patient outcomes has been used to support the centralisation of some services such as stroke and trauma care along with highly specialist children's heart surgery.

The debate begins where there is less of a link

between volume of activity and outcome. This means other factors should be considered including nurse staffing and hospital system resources. In most cases reorganisation will focus around particular pathways and the key to finding good evidence is to measure what has most relevance to that pathway.

2. Resources

Many acute sector organisations are in a position where the day-to-day running of the organisation consumes the time and energy of the entire senior management team. This means that when a service reconfiguration rears its head the knee-jerk reaction is to find individuals with spare capacity and often they have less direct experience in reconfiguration. As a result senior leaders do not get involved and the reorganisation suffers.

David Burbidge, member of the Allocate Software Executive Advisory Board and Director of Corporate Affairs, University Hospital Birmingham NHS Foundation Trust, says that in his experience the best outcome requires the best team. That means putting a team together that includes the most experienced senior managers. "Your top people need to be on the job," he says.



Key Point

It is vital that, even though their time may be committed to the day-to-day running of the organisation, any service reconfiguration team is made up of the most experienced senior managers rather than a team made up of managers with spare capacity.

One other reason for have senior figures involved is that it will help to encourage buy-in from the rest of the senior management team and from the board. The organisation has to act in unity otherwise cracks may start to appear, for instance between senior clinical staff and the non-executives. This in itself can lead to further loss of confidence in the course of action being proposed.

The need to have top team involvement may be obvious but this is rarely possible to achieve. So other ways have to be found of bringing their influence to bear without them getting involved in the 'trenches of reorganisation'. Burbidge says: "A sensible approach is to have a good second team that is ready to pick up. Carrying out due diligence and putting time into research is perhaps the most important part of the process so you need a team that knows what it is doing."

Given this second team needs to have the best chance of success one way of passing on senior-level experience is to set up a steering group consisting of senior leaders. Another option is to set up a mentoring programme that makes the most of their individual experience.

There is often a temptation to sit back once the regulatory boxes have been ticked and reorganisation is underway but resource is still required after the ink has dried. Experience has shown that a steering group, or mentoring programme needs to continue well into the implementation stage. This is often overlooked and it is nearly always the case that the team taking an organisation into a restructure is not the same team that carries out the restructure.

3. Rules

The regulatory regime for acute providers is likely to become increasingly demanding as foundation trusts are freed of central control from the Department of Health. The foundation trust regulator Monitor has already signalled its intent by highlighting a number of high-profile breaches of its terms of operations. Its remit has now been widened to include economic regulation. This means it will cover competition and continuity of service.



There is also an increased likelihood that reorganisations will be referred to the CCP and, as we have seen, the CCP is taking a hard line on those that aren't able to show improvements in quality and benefits for patients.

The Office of Fair Trading (OFT) could also become involved. The OFT has published working arrangements with the Department of Health and CCP. The OFT believes the CCP has an important role to play in promoting competition and best practice in the internal NHS market. The working arrangements acknowledge the continuing role the OFT plays as the only UK authority with statutory duties to apply competition legislation to the public and private healthcare sector in the UK.

The Care Quality Commission has a more frequent and rigorous inspection regime, a trust may find that the Quality Risk Profile of its new partner may warrant a higher chance of inspection. Change introduces inherent risk; ensuring that processes and procedures on the



Key Point

With the CCP and the OFT increasingly involved in reconfigurations, understanding the wider regulatory environment is a crucial to success.

frontline change to reflect the new organisation, so that policies and practice quickly become common is key. To achieve this it is suggested that a single assurance/governance team is created early on and that a single assurance process and reporting strategy is quickly adopted. This is important if organisations are to ensure

they do not fall foul of the rules and risk patient safety, the reputation of the organisation or the licence to operate.

Acute providers therefore have to navigate a regulatory minefield and one where the regime is not set up to give them the space they need to make reorganisations work. Mergers or acquisitions take time, issues of different organisational culture need to be resolved and this does not happen overnight. Yet, there have been instances where, following a reorganisation, Monitor has continued to look carefully at performance against its standards rather than allowing breathing room for mistakes to be rectified.

Some argue a certain level of scrutiny is still required. Standards have to be maintained because the delivery of safe care is paramount. David Foster believes you can't give too much room: "Yes, there may be time when an organisation feels over scrutinised but you have to watch your outcomes and the system can't always be blamed for variation – you can't take that risk with patients."

While there is still some way to go in the debate and discussion around risk monitoring, understanding the regulatory environment is a key ingredient for success.

4. Rhetoric

Any reorganisation runs the risk that it will arouse the concerns of a local population particularly if a service is going to be re-located. Once the public's concern has been raised it is only a matter of time before politicians get involved. Their involvement can itself stoke further concern and anger.

There are signs that politicians are willing to grasp the nettle and a handful have begun to accept NHS acute sector reorganisation is inevitable, but we have yet to see wide recognition within the Houses of Parliament.

Angela Huxham, member of the Allocate Executive Advisory Board and Director of Workforce Development, Kings College Hospital NHS says: "In the NHS you often hear a lot of rhetoric when it comes to a merger or acquisition. It is one thing to sit at around a table



Key Point

Consider how your organisation can engage with governors, staff and health and well-being boards to help communicate changes across the local health economy. Engage clinicians in the delivery of the communications programme.

Huxham says: "The key is to be able to articulate the vision so every member of staff can say I know why we are going through this and I can see a clear route to realising the benefits within a foreseeable timescale. There is no single right way to communicate with staff as individuals receive information in different ways. Reaching them requires many channels to outline the issues, from face to face meetings to e-bulletins, clear, concise intranet pages and regular updates."

5. Risk

Risk can be viewed in two ways. First there will be a risk to the organisation of undertaking the merger or acquisition. This is the risk associated with not being able to meet existing requirements either in terms of safety, patient care or regulatory demands. This risk has to be explored as part of the business case that is being made.

Second is the risk of failure. For the NHS talk of merger and acquisition is still a relatively new concept and so too is risk of failure. In the past the Department of Health has stepped in to pick up the pieces when things have gone wrong. The changing environment means this will



Key Point

The changing environment in the NHS makes it mandatory that an examination of the cost and impact of failure must go hand-in-hand with an assessment of the benefits.

Consider how your current processes and reporting will keep the organisation focused managing and recognising merger risk.

no longer be the case. Monitor will be actively involved throughout the reconfiguration and in overseeing clinical reconfigurations after financial failure but, as witnessed in South London, this will not be a 'bail out'. Its contingency fund will be used primarily for sorting out the problem, not helping to turn a service around.

Examining the cost and impact of failure therefore must go hand-in-hand with an assessment of the benefits.

Both sets of risks should be identified, modelled and managed. It is commonplace in the private sector and is likely to become much more so within the NHS.



Conclusion

The issue of structural reorganisation is a complex one and requires skill sets and an approach that is still, despite many reorganisations, relatively underdeveloped in the NHS.

There are many organisations, both in the private and public sectors, that have already been through the process (both with and without success) and they will provide helpful learning points for others.

The NHS examples should still be of interest in the years to come because cultures do not change overnight and

new organisations can take years to find their feet.

The Allocate Executive Advisory Board has prepared this briefing as a short guide to highlight areas that should be taken into consideration by organisations considering structural reorganisation – whatever shape it comes in.



Questions to ask

1. Operational

Will the new entity deliver better quality of care?

Will the new entity deliver profitable performance in a financially sustainable way?

Can the integration and required restructuring actually be delivered?

Is there the capability and capacity to deliver change alongside business as usual?

2. Clinical

Have clinicians led on design of services/service delivery/pathway configuration and change?

Is there agreement amongst clinicians on the proposals?

Is there a fit between the clinical strategy and commissioning intentions?

3. Performance

Does the business case demonstrate how and when clinical benefits will be delivered?

Does the business case demonstrate how clinical quality will be improved as a result of the merger?

Are the processes proposed to monitor and manage clinical performance clear and robust?

Is there clarity on where and how performance will be improved for the merged entity?

4. Cost improvement

What is the overall cost improvement target?

How does this break down year by year and is this in line with agreed targets?

Does the cost improvement reflect the productivity opportunity identified?

Are savings schemes clear across the individual trusts and are they achievable?

Are there clear accountabilities for delivery?

Is there a clear difference between merger savings and productivity gains?

Advisory Board

This report was produced with the guidance and input of the Allocate Software Executive Advisory Board.

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