REFORM

Takeover: Tackling failing NHS hospitals

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The authors

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Between June 2007 and March 2009 he was the Director of Strategy and Commissioning at the London Strategic Health Authority.

Since then Paul has been working as a management consultant and an executive coach helping leaders within the NHS create and develop step changes within their organisation. As a columnist and a blog writer he continues to argue for NHS reform. In September 2011 he wrote with Caroline Mitchell the pamphlet: *The hospital is dead, long live the hospital*, published by *Reform* .

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In 2004 Simon took a secondment from his role as Executive at Accenture to help establish what became a £30 million transformation and service integration programme at the London Borough of Lambeth, staying on as the Divisional Director responsible for strategy, transformation and technology services. During this period, Lambeth successfully completed its journey from being rated “Poor” at the start of 2004, to being rated by the Audit Commission as a Three Star “Good” council in 2008.

Simon has been subsequently involved in public service transformation at a national level as a Local Improvement Advisor to the UK’s Regional Improvement and Efficiency Partnerships and a member of the CBI Local Government and Health Panels.

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1 Executive summary

Last year, Professor Paul Corrigan and Caroline Mitchell wrote a report for *Reform*, *The hospital is dead, long live the hospital*. They argued that over the course of this Parliament many NHS hospitals would have to change their business models radically or face closure. Attempts to protect all of England's hospitals from closure or reconfiguration would cost the Chancellor at least an extra £5 billion in bailouts by 2013.

Most experts and leading health research bodies concur with this analysis. In September 2012, the Audit Commission found that the number of hospital trusts and primary care trusts running a deficit doubled in just one year. Also in September, the Royal College of Physicians reported that many acute hospitals are "on the brink of collapse". The same month, in Dealing with Financially Unsustainable Providers, the Kings Fund argued that the problem needs to be "tackled" urgently.

In this second paper, Professor Corrigan, John Higton and Simon Morioka estimate that between 20 and 30 NHS hospitals are failing and will need particular attention during this Parliament. They explain that hospital closures are not the only answer to a failing hospital; indeed the threat of closure can arouse resistance to much needed change. The NHS should give much greater attention to allowing other organisations to takeover and turn around failing institutions. Takeovers should not protect the status quo; instead, they must be a catalyst for improvement. To cut costs and improve the quality of care service need to be transformed.

To date, approaches for dealing with failure in the NHS have not generally worked. Either hospitals have been bailed out – effectively subsidising failure – or they have been forced to merge with other failing hospitals; only to create bigger failing institutions. Even now, there are a significant number of mergers anticipated in the hospital sector within the NHS.

There is some positive progress, but the pace of change needs to accelerate. This year, Circle, a private company, took over the management of Hinchingbrooke, a failing NHS hospital in Cambridgeshire. In its first six months it achieved the highest patient satisfaction ratings in the region, up from the lowest a year ago, and there have been dramatic improvements in clinical performance. South London Healthcare NHS Trust has been put into administration and next month the administrator's report will be published. One obvious conclusion would be for the hospital to be disaggregated and its constituent parts taken over.

Looking at case studies and published research, the authors examine the body of evidence about why past mergers have not worked and identify the key determinants of success. Fundamentally, they argue, the acquiring organisation has to be able to change the business model and the working practices of the staff. They look at the policy architecture enshrined in the Health and Social Care Act 2012, and draw up a four-point plan for Government to create the conditions for successful takeovers:

- Admit that there are a significant number of failing hospitals. Politicians routinely make political capital by campaigning to save hospitals. Instead they should spend their time criticising the same hospitals for not providing much better services.
- Stop the policy of merging failing hospitals with other failing hospitals. "Supporting mergers between unsuccessful NHS hospitals because you cannot find anything else to do with them is not going to suddenly make mergers a successful method of improving failing hospitals."
- Incentivise organisations to take over failing NHS hospitals. Success will depend on the ability to attract strong NHS Foundation Trusts and the private sector, in England and abroad. Reforms have already been introduced that should encourage takeovers. Provisions in the Health and Social Care Act now mean that Foundation Trusts no longer have to disestablish themselves to acquire another organisation. They would still have to should they merge.
- Make it easier for the organisation that takes over a failing hospital to make the improvements that will improve services. The Government should signal its support for radical change. This will pave the way for hospitals to sell the idea to their clinicians and local populations.

In time, chains of hospitals could be run by the best NHS Foundation Trusts and private companies, which would develop centres of clinical excellence with strong brands – spreading best practice and achieving economies of scale. This pamphlet is about how to make this happen. It offers a strategy for turning failing hospitals into sustainable and cost-effective providers of high quality healthcare

2 Introduction

All around us, institutions are changing rapidly to meet new technological, financial and consumer expectations and circumstances. The level of change is unprecedented, and yet as consumers of services, we demand that the institutions we rely upon keep up-to-date and meet our expectations of modern service delivery.

When we work inside such institutions, sometimes the pace of change can appear too fast, and our natural instincts are to defend the past against the future. However, change always wins out. Our institutions either successfully navigate this process or if they don't, they often fail and disappear completely.

The argument behind this pamphlet is that NHS hospitals are no different. Our hospitals are undergoing unprecedented change. Some will succeed, and some will fail.

The question is what we do as a society with those that are failing. It is not enough to simply seek to defend them, whilst the care they provide becomes less and less optimal. The care provided by failing hospitals already costs more than it should, and provides worse results.

This pamphlet explores why hospitals fail, what we can do when they fail, and the role of takeovers within this process. Our argument is that since there is no escaping change, there is no escaping the implications of such change for the NHS, but that there are lessons to be learned from the past which point to ways in which hospitals can be made to work better in the future.

We start with the recognition that NHS hospitals are, in one sense, no different to any other provider of public or private services. There is, inevitably, variation between the hospitals within the NHS – some are good; some are okay and some are poor. The difficulty is that the "universality" of the contract between the NHS and the public has created something of a false premise. A large section of the general public believe that hospitals should be, and are, equally good at everything. Everyone in the NHS knows this is not true, and the Government has the duty to make this reality clearer.

As with all other services, hospitals can improve through hard work and many do. But there are some who have been near the bottom of all reasonable variations between bad and good for some time, hospitals where all attempts at improvement have failed. For as long as these hospitals continue in their current form, they are providing a poorer service to the public than the public have the right to expect.

In this pamphlet we explore the role for good hospitals in taking over poor ones as an alternative either to trying to defend the status quo, or to initiating a merger of equals which ultimately results in the widespread failure and closure of those same institutions upon which the public rely. In advocating this, we need to start by addressing the recent history of mergers and acquisitions within the NHS in the context of future potential takeovers.

There is already a mass of literature about mergers and acquisitions within the private sector, and a developing body of work within the public sector, addressing how such activity fails to deliver promised value – and worse, may actually succeed in destroying it. And yet, more often than not, this process has been seen by successive governments as the default solution to underperformance in the acute sector.

We acknowledge that past failures are not simply failures of strategy, due diligence or planning. When we look at the current landscape of trusts, we see the results of numerous joinings together of organisations that are fundamentally incomplete. A simple way of looking at this is that bringing two failing organisations together, and doing nothing about the reasons they are failing, simply creates a single very large failing organisation. The corollary of this is that in the vast majority of cases for a successful organisation to help turn around a failing one, all parties need to appreciate from the start that this is a takeover of one organisation by another, and not a merger of equals.

Our argument is nonetheless that properly constructed takeovers can improve health care outcomes and improve value for money in relation to those outcomes. This will require tough and determined action to address those parts of NHS organisations that diminish value, and to encourage those aspects that enhance value. As such, we will explore some of the key determinants of successful organisations, the difference between a merger and a takeover, and what this might mean in the context of the hospitals of the future.

We recognise that takeovers will potentially destabilise and threaten the deep-seated psychological contracts that many senior clinicians and patients have with the NHS, and that failure to attend to this may result in takeovers being abandoned or the promised benefits being missed. We therefore include an assessment of how a takeover agenda can be pursued in a way which is founded on a rational and evidence-based solution, but also acknowledges and addresses the professional implications, disruptions and fears in play. And we consider where the medical establishment should take a lead in creating the conditions for success.

Addressing the challenges facing healthcare delivery in the UK is not simply about improving the way in which acute trusts develop in relation to other acute trusts, but without tackling this issue there is a real danger that these institutions, central to the NHS of today, will increasingly become an obstacle rather than a support to the NHS of tomorrow.

3

The case for change: allowing failing NHS hospitals to fail

The answer to this question is different if you work within the NHS than if you are a member of the public. Clinicians and managers have known for decades that some hospitals are very much better than others. When their friends and family are ill they know where to recommend for the best treatment.

It was only 11 years ago that the first information was published on how well the Government felt NHS hospital trusts were doing in comparison to each other. In September that year the Government published a star rating which said that 32 out of 150 hospital trusts had 3 stars out of a possible 3, and 18 had no stars at all. Because this was such a stark judgement it caused a furore and over the years healthcare regulators have dropped this simple rating system. This means that at the moment the public do not have access to a clear Government rating system for their hospitals.

Compare this to state schools. In 1996 the first school in England was described as "failing". This also caused a considerable row, but over the next few years became one of the established ways in which the public was informed about state schooling. Now, if you want to know about the school your child will go to, it is established practice to be able to consult the Ofsted report on that school and find out how they perform in relation to a number of simple categories.

There is no such straightforward classification for hospitals. This begs the question, why?

Over the last 60 years the public have been led to believe that the NHS provides services that are equally good everywhere and for all of its services. Not only is this prospectus not true, it cannot be true of any large scale national service whether public or private.

All large scale services have better and worse outlets. In the private sector if there is a national organisation, some of the local delivery mechanisms for that national organisation will be better than others. People talk about this all the time. This branch of a supermarket chain is better than that branch; this train service better than that one. In every aspect of service delivery we expect differentiation and talk about it a lot.

In many of these areas of life we act upon that information. The national organisations responsible for this look closely at how individual branches are doing, and they make sure that the ones that are worse learn from the ones that are better. If branches do not learn to improve, the ones that are worse will lose more and more business, to the point where ultimately they close.

So we are used to differentiating between outlets, to acting on those differences, and we are used to the organisations that run those outlets trying hard to improve.

But apparently our expectations of NHS hospitals are different. The public expect them to be equally brilliant for all their services, all the time, everywhere. By and large, for most of the 65 years of the NHS governments have been pleased to collude with this and not confront the public with the fact that some hospitals are better than others.

Whilst both New Labour and Coalition Governments have professed a desire to give the public much more information about their hospitals and have celebrated the success of the best, no government has been able to describe honestly the true number of problem hospitals within the NHS.

It is this failure to develop a ruthlessly honest relationship with the public that has more than anything else led to the lack of policy about how to deal with failing NHS hospitals. The last few years have seen the odd desultory discussion about setting up a "failure regime". It is very important that in July 2012 the first hospital, South London Healthcare NHS Trust, is going through that regime.[1] But over the last ten years and even today no Secretary of State would say that they expect, for example, 20 or 25 hospitals to go through such a regime in the next two years. But as we shall see, the problem is on that scale.

One hospital that has had enormous publicity about the death rates in its emergency admissions is Mid Staffordshire, which has been vilified in the national and local press. It has now reached the reputational point that doctors will not go and work there, and the Accident and Emergency department has been

1 Department of Health (2012), "South London Healthcare NHS Trust to be put into the Regime for Unsustainable Provider", 12 July.

partially closed. Yet still the hospital has not been labelled as failing, and patients are still being sent there.

Secondary schools are complex organisations. A school can be really good at languages and not so good at sciences. An overall rating has to deal with variable success within the constituent parts.

Despite this, Ofsted has created an overall currency that is accepted publicly as describing this complexity within a particular judgement. Schools may complain that a bad overall judgement misses out some very good components in its overall nature – although interestingly no school complains that its bad parts are in some way covered up by a good overall judgement. But all of this implies that it is possible to make worthwhile judgement.

In fact as Ofsted has developed the process of judgement, improvement and further judgement, its impact has been greater and greater. After 15 years of this process, schools have become used not just to being judged, but to recognising that not being good at Maths, English and Science means not being good at all. This has led to greater and greater concentration on what is successful in a school. Now it is difficult to call a school "good" without being good at least at those three elements.

It is true that hospitals are more complex than schools. Even the best hospitals in the country do have some services that are not very good; and conversely the worse hospitals will have some parts of their services that are very good. So making an overall judgment about a hospital would be problematic for both these bad parts that could be hidden within an overall good judgement and vice versa. But as with schools certain issues would over time become the equivalent of English, Maths and Science. They would be seen as essential.

One such issue that has become vital in the last ten years is cross infection. All hospitals have more sick patients going through them now than ever before. Patients in hospital are older and sicker and because there are more patients going through the hospital with shorter stays, there are more patients in any week in a hospital. This makes hospitals places where cross infection is a real danger. It is now clear that, as far as the public is concerned, cross infection in a hospital has become an issue which is more important than any other. If you are afraid to go in to hospital because you might get sicker than you were before you went in, then it is not a good hospital, however good its other services are.

Most people would also say that whatever we think about the excellence of its individual surgeons, if the other hospital staff with whom you interact do not treat you with value and dignity, then the service that the hospital provides you is just not as good as it could be.

So we would argue that we can make differentiating judgements about hospitals and therefore recognise that some are better – much better than others. This automatically means that some are worse – even much worse – than others.

Those of us who work in and with the NHS have a responsibility to communicate this knowledge, which for the most part is internal to the service, to the wider public. We know that the difference between one hospital and another for the same intervention with similar patients can be very different, and that this matters for the individuals and families concerned.

Dr Foster's *Good Hospital Guide* currently lists 19 hospital trusts that have high mortality rates measured both with the in-hospital measure (HSMR) and the all-deaths measure (SHMI).[2]

Blackpool Teaching Hospital NHS Foundation Trust

Buckinghamshire Healthcare NHS Trust

Burton Hospital NHS Foundation Trust

Dartford and Gravesham NHS Trust

George Elliott Hospital NHS Trust

Isle of Wight NHS Primary Care Trust

Mid Cheshire Hospital NHS Foundation Trust

North Cumbria University Hospitals NHS Trust

Northampton General Hospital NHS Trust

Northern Lincolnshire and Goole Hospitals NHS Foundation Trust

Shrewsbury and Telford Hospital

The Dudley Group of Hospitals NHS Foundation Trust

The Royal Wolverhampton Hospital NHS Trust

United Lincolnshire Hospitals NHS Trust

University Hospitals of Morecambe Bay

Worcestershire Acute Hospitals NHS Trust

York Teaching Hospital NHS Foundation Trust

Chelsea and Westminster Hospital NHS Foundation Trust is the only trust that is low on all four mortality indicators.

The public have the right to choose which of these hospitals to go to, and policy and practice in the NHS has a responsibility to communicate that choice clearly to them. If patients make the choice to go to the hospital with the better outcomes, then that hospital gains from this.

Of course, hospitals can improve. This is true of all institutions in the public and the private sector. Hospitals can recognise that they are slipping behind other hospitals and they can work to transform their clinical and financial outcomes. As part of this process, they can look at comparative information in relation to similar organisations, and apply improvement techniques to achieve better and better levels of performance. Many do, and turn themselves round.

But consistently, over time, others do not. They achieve much poorer outcomes, or live with troubled finances, over a prolonged period. In the private sector, competition finishes off these organisations. Our point is that this does not happen with NHS hospitals, and it needs to. We believe that hospitals, like other institutions, do actually fail, and we need policy and practice to deal with this when it happens.

Addressing this issue means first understanding what we mean by failure. There are two major experiences of failure in a hospital setting, and our experience is these often occur together. The first is the failure of an organisation clinically; the second, the failure of an organisation financially.

Clinical failure

Clinical failure occurs when significant parts of an NHS organisation fail to provide standards of care that are at the average level of provision for that care. It may be shocking to a lay reader (but interestingly is old knowledge to any health care insider) but hospitals in many areas are significantly below the average.

Why do these variations in outcomes occur and why are they getting worse?

One of the main private sector commentators on health service outcomes is Dr Foster. Over the last ten

2 Dr Foster (2011), *Inside your hospital*.

years it has been commentating on hospital outcomes and the November 2011 publication made it clear the reasons for variations.

> "For some conditions, greater concentration of specialist services in fewer but high performing hospitals is required. For other conditions, providing services locally at weekends and evenings is the answer. It means changing the way our hospitals work."[3]

This is disarmingly simple, but true. We can reduce variation by changing the ways in which our hospitals work. However, this does not mean that every hospital can become excellent at everything.

A significant part of the problem is that the hospital is the major symbol of medical organisation and the epitome of security. That is why the "local" hospital matters. It feels like a matter of life and death to have one at the end of your road.

> "Unlike most other organisations they are trying to do everything for everybody and, especially given the development of specialisms in health care this is becoming impossible. Because they try and do everything for everybody they have become used to having massive overheads which renders them as complex institutions and very difficult to make enough money to thrive."[4]

The idea that any institution in any service or industry can provide everything for everybody all the time is not only very inefficient, in medicine as in many industries, but this inefficiency is reflected in the quality of outcomes. Over the last 200 years it has become clear that in most industries and services the division of labour is a good thing. If you specialise in certain parts of an overall process this leads to better outcomes. The same is true of medicine.

If as a health professional you carry out 150 procedures a year, then you are more likely to become proficient and safer than if you are carrying out 15. Moreover, with the increased specialism that takes place every few months as an area of medicine advances, not everywhere can carry out the number of procedures in new specialisms.

We now know that if you have a stroke and are treated within four hours you have a much better chance of survival and of limiting the impact on your life. However, there are not enough strokes taking place for every hospital to have the knowledge and capacity to work with a stroke victim 24 hours a day, 7 days a week in that crucial period. If you try and say that every hospital can be capable of working at the very best level with a stroke victim, then none of them will be carrying out their care at the optimum level – none of them will be working with sufficient stroke victims to be at their best.

If, however, you concentrate these stroke units in a small number of hospitals they become safer because they are working with enough patients. The corollary of some hospitals doing this is that some do not and therefore that service is not available in every hospital.

Safe, quality medicine must be driven by this dynamic. If we try and pretend that everyone can do everything, nearly everywhere will become less safe than it could be. If some hospitals stop providing some procedures and others continue, the whole system becomes safer and of better quality.

The problem for the NHS is that political and public pressure has acted as a brake to this specialisation. Politicians of all parties have promised the public that the NHS will provide everything, everywhere, and understandably the public have subsequently acted to resist any attempt by the organisations of the NHS to deviate from that promise. Unless we try to change political and popular perceptions, some people will continue to receive unsafe and sub-optimal NHS care. It is within this context that clinical failure takes place.

Given the regular improvements in medicine that new knowledge can bring, there is a potential for regular, rapid improvement in health outcomes. Those hospitals that carry out a large number of any procedures generally have better outcomes than those that do not. This means that the variation of outcomes between one group and another increases as the best get better, and the ones who do not stay where they are or get worse.

By this logic the variation between those that have the best outcomes and are improving, and those that are not, will get bigger. This means that if we define a failing hospital as providing services that provide outcomes that are worse than the average outcome for a significant number of services, it is likely that more hospitals will come into that category.

3 Dr Foster (2011), *Inside your hospital*.
4 Corrigan, P. and Mitchell, C. (2011), *The hospital is dead, long live the hospital*, *Reform*.

There are two ways to stop this happening. First, stop the best from getting better. Second, recognise that the worst are bad and act to radically change them.

Financial failure

The finances for public services in England in 2012 are constrained. It is difficult to see how, for the foreseeable future, there will be any more funds for public services than there are at the moment. In fact, the greater likelihood is that there will be less.

In the summer of 2009 and throughout 2010, the Coalition Government pledged that the NHS would be "protected" and that they would ensure the NHS received additional resources in real terms. Given the likelihood of an even tighter squeeze on public spending, it is just not possible to see the NHS obtaining significantly more resources than it has now. However it is certain that over the next few years the demand for health care will rise – perhaps by as much as 4 per cent a year. All of this means that over the next ten year period demand may increase by as much as 50 per cent and resources will probably not increase by very much at all.

Under these circumstances the pressure on hospital trust finances will be considerable. What does financial failure mean? In some ways this is a simple definition. An NHS acute hospital receives income from a wide variety of sources. NHS commissioners buy health care from hospitals and they pay for the number of episodes of health care that the hospital carries out on the basis of a national tariff. Some hospitals have a cost base which means that they can make a surplus on enough of those tariffs to make an overall financial surplus. Others have not borne down on their costs sufficiently to be able to make a surplus and they make a loss. If a hospital consistently has greater expenditure than income then it is a financial failure.

What are the options when a hospital is failing?

If we have one failing hospital every ten years then the system can deal with that failure in an ad hoc way. However, this pamphlet starts from the proposition that, as with other public and private sector services, hospitals failing for clinical or financial reasons or a combination of both will be more than just a one-off ad hoc occurrence. We believe that today there are at least between 20 and 30 hospitals that are either failing, or are on the verge of failing.

Given this number, it is important to have policies and practices that deal with this failure. This must start with an honest discussion with the public about the reality of failure: that it is not a rare phenomenon.

One of the obvious first things to do with a failing hospital is to try to stop it from failing. This can involve the application of tough performance management and improvement regimes. Change under these circumstances may be exceptionally painful for all involved, with the risk, that if an institution can side step the pain, the associated hard work and potential conflict, then it will. The questions that any reasonable institution will ask in such circumstances are: "Do we really have to do this?" and "What will happen to us if we do not?"

A very good question to ask about the efficacy of takeovers is why a change of organisational structure and leadership is essential – given we know that any change of structure can mean the organisation consuming itself with changing the structure, and not getting down to the difficult business of real change in how it works.

But one of the main definitions of a hospital that is failing is that – usually for a long period of time – it has failed to carry out successful long term change. It has not gone through the very hard and painful work of sustained and irreversible changes that are necessary to turn the corner from failure. If it has done that, then it will no longer be failing.

In this pamphlet we are dealing with institutions that have tried, often through many different chief executives, to carry out the necessary changes, and have failed. Within these circumstances, we would argue that the organisation needs new, proven leadership to make the changes that the previous organisation has failed to deliver. Under these circumstances, the organisational turmoil of a takeover is a necessary part of change.

However, in the NHS if a hospital knows that it is going to be subsidised when it does not successfully drive through the hard changes, then there is little incentive to make those changes. The alternative to the hard work of change in most private sector institutions on the contrary is stark: if you fail to change, then your organisation closes.

One further way of dealing with failure is therefore to allow a hospital to close, and to cease providing services completely. Traumatically, in other service areas this is what happens. One day an organisation is providing services, and when its market finally collapses, it closes and the organisation disappears.

Hospitals provide services that are essential to the public and simple closure as happens to a factory or a shop is simply not considered politically or morally possible. Whilst the commercial or medical logic might demand the closure of the organisation, this is almost never what happens. One of the problems for the NHS and politicians is therefore that hospital subsidies end up as the only alternative to hospital closure. The reality is that if local and national politicians believe that the only alternative to subsidising a hospital that delivers sub-optimal services is closure, they will argue loudly for subsidy.

If there is no alternative but closure, then this also leaves local politicians and people arguing to keep open a hospital that they know provides sub-optimal services. It is a dreadful outcome when local democratically elected politicians are arguing to keep open services that serve their local people badly, when it should be the task of local democratic representatives to denounce the fact that local services for their public are not good enough. This "catch-22" has often reduced the democratic representatives at the local and national level to trying to hide bad news about local hospitals in case it leads to closure, rather than shining a public spotlight on it and demanding change and improvement.

Of course it is in the interests of the failing hospital to say that the only alternative to subsidy is closure, if that means local and national politicians, together with the public, are frightened into defending the status quo, however bad that is. If this is the choice that the NHS organisations provide to politicians, then it is hardly surprising that politicians support the status quo.

The main aim of this pamphlet is to demonstrate that there are alternative policies and practices for the future of failing hospitals rather than closure. It is possible to develop a better hospital from the core of a failing one, but this will only be achieved by profound and systemic change to the structure of the hospital. And the surest way of achieving this, learning from recent NHS history, is not a merger of equals, but the process whereby a very successful hospital takes over a failing one.

An institution that takes over a failing hospital will do so because it believes that, taken together, the two institutions can deliver significantly better health outcomes for the same level of resources. The new management will be strongly motivated to carry out changes that have not happened in the past.

As we shall see, the vast majority of mergers that take place within the NHS fail in this objective. The merger that destroys value rather than creates it is still too often the rule. Yet it is possible to conceive of a takeover that successfully achieves the required level of change for all of the organisations involved, and there are strong reasons for believing that learning from the past is an essential step towards better outcomes in the future.

In the following sections of this pamphlet, we advocate *takeovers* as the best solution for failing hospitals, as opposed to mergers or acquisitions of the kind the NHS has seen in the past. In our terminology, a *takeover* may well involve the acquisition of assets and some merging of operations, but the distinguishing characteristics of a *takeover* are that:

- power over the failing institution is given to the leadership of the organisation taking it over;
- a new care model is implemented in the failing hospital, which is either the model followed by the organisation taking over, or part of a new integrated model spanning multiple hospitals with the design led by the organisation taking over;
- the organisation taking over has the capability and capacity to drive the change and is able to deploy the performance systems necessary to track progress towards a successful and sustainable future for the failing hospital.

4

The problem with the current policy of mergers of NHS hospitals, and what we can learn from other sectors to make takeovers a success

> "We therefore conclude that there seems to be little hard evidence that this attempt at government planning of hospital care has achieved much more than simply reducing hospital admissions. This removal of capacity may reduce patient welfare. We show that waiting times rose post-merger; travel distances may also rise when hospitals are closed. Consolidation also downstream reduces potential competition, which has been shown in the UK market to have some beneficial effects on patient outcomes and length of stay... Given this, it seems the English government should carefully consider potential losses before allowing more mergers between short term general hospitals."[5]

NHS mergers are not new. What is new is a fully fledged takeover. In this section we develop the argument that there is a big difference between these two very different approaches to dealing with failing hospitals.

Mergers within the UK health sector are not new. The trusts we see today are a reflection of a mass of past activity, as a 2012 study by the University of Bristol highlights: "out of 223 short term general hospitals in England in 1997, 112 had merged between 1997 and 2006".

Given the number of trusts in existence that are the result of a merger, it is understandable that a merger is the form of organisational challenge that the NHS first turns to in times of need. In the context of an increasingly challenging operating environment, there is an understandable temptation to look again to safety in scale – to seek viability, in the integration not only of the way in which services are provided, but of the organisations that provide them. Yet for anyone considering embarking on this path, the outcomes of past investments in merger and acquisition (M&A) activity across both the public and private sectors provide a salutary lesson.

Given the role that they have played in shaping both public and private sectors, it is not surprising that there is a mass of literature relating to mergers and acquisitions. Much of this literature relates to failure.

In *The Synergy Trap*, Mark Sirower analysed 168 private sector M&A deals between 1979 and 1990. Of these, he found two-thirds destroyed value for shareholders.[6] By 1999, after a further decade of explosive growth in private sector M&A activity and in the literature examining its successes and failures, global accountancy firm KPMG were still able to conclude that of the 700 top international M&A deals by value of the previous 3 years, "83 per cent of mergers were unsuccessful in producing any business benefit as regards shareholder value" and "as many as 53 per cent actually destroyed value".[7]

The lexicon of research into the long term outcomes of mergers and acquisitions continues to grow, but one simple theme remains the predominant one – that mergers and acquisitions, despite the huge sums of money and talent invested in them, often fail; and that this failure is achieved at significant cost, not just in the cost of the process itself, but in the destruction of existing value and in the opportunity cost of not doing something more effective instead.

In this context, it is perhaps unsurprising that Bristol University's study found that the most recent wave of UK hospital mergers – analysed in terms of financial performance, productivity, waiting times, clinical quality and labour productivity – produced precious little evidence of benefits, whilst deficits in many cases actually increased. Given understandable sensitivities around the future of local hospitals in communities across the UK, such findings have garnered press attention and raised important challenges around the strategy of hospital mergers.[8] These include:

5 Gaynor, M., Laudicella, M. and Propper, C. (2012), *Can governments do it better? Merger mania and hospital outcomes in the English NHS*, Centre for Market and Public Organisation, Bristol Institute of Public Affairs, University of Bristol, January, p. 17.
6 Sirower, M. (1997), *The Synergy Trap: how companies lose the acquisition game.*
7 KPMG (1999), *Unlocking shareholder value: the keys to success*, November, p. 2.
8 *The Guardian* (2012), "NHS hospital mergers fail to produce gains", 12th January; *The Independent* (2012), "NHS mergers solve nothing", 12 January; *News Shopper* (2012), "Report says hospital mergers bring few benefits as NHS trusts in Dartford and Medway plan merge", 16 January.

1. Why should trusts risk taking over other hospitals, in preference to the other ways in which they might try to reduce the cost or improve the quality of their own services?
2. What, if anything, is likely to be different in relation to future takeover activity in the sector, given the less than positive experiences of the past?
3. How can organisations that decide to go down this route, either of taking over or being taken over, improve their chances of success?

Addressing these questions is fundamental to ensuring that the mistakes of the past are not repeated.

Why bring together existing hospitals?

Former health secretary Frank Dobson notably described NHS waiting lists as a "supertanker", evoking all the associated challenges of turning them around. Yet the NHS itself might be better conceived, in the analogy of Professor David Kerr, as "a flotilla of small ships", trying to sail towards a common destination, buffeted on a stormy sea.[9]

If the NHS has lost some of its national character, not least in relation to increasing regional differences across the nations that make up the UK, it is one of the few public services which despite its problems remains a much-loved national brand. It can, at times, behave monolithically; there are still many similarities between its constituent parts. And yet at the front line it is a collection of individual providers of healthcare services, all operating with varying degrees of autonomy, all – from the very best, to the very worst – facing significant challenges in the coming years in relation to improving the quality of clinical outcomes, whilst reducing the associated costs.

NHS mergers and acquisitions are unlikely to ever be subject to the degree of leveraging that occurs in the private sector, or the same market pressures that might lead to such a precipitous decline. Hospitals cannot, however, escape the reality that at a time of increasing focus on community-based preventative care and on-going reductions in overall public funding, larger trusts do not necessarily equate to more sustainable ones. In a declining market, size may simply mean disaster, faster. So why does it matter to the hospitals of the future?

Costs and quality

> "Interviews with finance managers indicated that the clearest source of potential savings from the merger was the £500 000-£750 000 that was associated with reduced numbers of members of management boards in the merged trusts. Finance managers were less convinced that other savings were achieved within the first financial year, and they had no clear evidence that savings were reinvested into services. Instead, they thought the mergers highlighted hidden financial problems in the constituent trusts and revealed differences in funding and staffing of services across the merged organisations."[10]

Much post-merger integration activity in the health sector to date has been based on the premise of a rationalisation of management costs, overheads and back-office functions; this undoubtedly has a part to play in any business case for integration, not least as a way of releasing resources to support a more fundamental transformation of services.

However, with annual expenditure at acute trusts measured in the hundreds of millions, it is clear that such savings can only be a small part of the overall case for a merger or acquisition. Without a more profound change to the way in which the organisations involved operate, the benefits of such integrations are inevitably limited.

Hospital overheads and management costs rightly attract a high degree of scrutiny, but the reality remains that the vast majority of the expenditure within an acute trust remains on doctors and nurses. In fact a *BMJ* study found that the average savings in management costs of £178,700 in the first year and £346,800 in the second year after merger did not even meet the stated objective of reducing management costs by £500,000 a year – in part because of the potential management demands created by the mergers themselves.[11]

Scale can produce economies, but that very much depends on the organisation in question. As Clayton

9 Kerr, D. (2012), "Business Meets Politics", Wellcome Collection, 31 January.
10 Fulop, N., Protopsaltis, G., Hutchings, A., King, A. and Allen, P., Normand C. and Walters R. (2002), "The process and impact of NHS trust mergers: a multi-centre organisational study and management cost analysis", *British Medical Journal*, 325:246.
11 Ibid.

Christensen and colleagues noted in their research on the causes of successes and failures of mergers: "If fixed costs represent a large percentage of your total costs, you can reap substantial savings by increasing scale. But if your costs are more variable than fixed, scale increases may require new overhead investments and so deliver minimal savings". Acquisitions based simply around economies of scale in administrative costs "often have disappointing effects".[12]

Many hospitals already outsource a whole range of support services to the private sector in order to achieve best value; others are looking at sharing individual back and front office services as a way of reducing overheads further, without the broader challenges and costs of a full integration of their operations. There are a range of options for organisations of all sizes looking to leverage economies of scale, or develop enhanced capabilities, without the pain or costs of a merger or acquisition.

It is at the core of any hospital, in its patient base and clinical workforce, that size is becoming an increasingly important element of future viability. In this context, the corporate merger is simply a means to an end, not an end in itself – and the ultimate goal is as much about quality as cost.

As noted, an increasing focus on quality within the NHS is already driving a focus on specialisation and the role of the consultant in the delivery of services. This has created twin pressures for the amalgamation of clinical services – the need for trusts to attract and retain sufficient consultants to be able to staff and lead the delivery of high-quality services, and the need for trusts to have a sufficient catchment area of patients for these clinicians to build and sustain the practical experience necessary to deliver consistent clinical outcomes. The reality that these trusts face is that there are simply not enough of either patients or experienced consultants to go around; and that what applies to the clinical side of hospital management and leadership, applies equally to the corporate side as well.

In May 2011, a nine month King's Fund commission into leadership and management concluded that NHS services might be over-administered, but if anything were under-managed.[13] In response to tightening budget pressures, overall management numbers continue to fall, and those good leaders and managers who are left are distributed across a fragmented provider landscape, or simply unobtainable for those trusts deemed too small or too ineffective to attract the required level of talent.

Resolving this imbalance means a rationalisation in hospital supply driving and in turn being driven by an overall improvement in quality, creating a smaller number of organisations with a greater depth of managerial and clinical leadership. This is not simply about the ability to manage the more mundane aspects of running a hospital trust – administration, facilities and estates, external contracts. Instead it goes to the heart of any organisation's ability to deliver high quality, cost-effective service through the way in which frontline staff, clinicians and managers work together to deliver the outcomes.

For all of the investment in the "improvement industry" across public services in general and the health service in particular, the reality is that there remain huge inconsistencies in the quality of clinical outcomes across the UK – in the starkest terms, large differences in the survival rates depending on where care is provided.

Amalgamating the best and worst does not guarantee that the best will prevail. A takeover carries the risk that, at least in the short term, the process of integration will disrupt the core business of delivering services to customers across all parts of the organisations concerned. A takeover nonetheless carries with it the opportunity to disseminate best-practice in a way that transcends historic boundaries, effecting new models of delivery across the combined organisation at a pace and with a rigour that would be hard to replicate in separate, stand-alone organisations. It is this form of systemic transformation that offers the best trusts the opportunity to establish themselves as quality brands within the NHS, attracting further custom and in turn allowing them through further mergers and acquisitions to extend the provision of quality services beyond any particular building or locality.

Acknowledging the potential benefits of these developments does not negate the fact that the best-run, most effective service organisations do not necessarily make the best acquirers or integrators of others. It also raises a significant question as to what this means for those existing trusts which will only ever be targets for acquisition, as oppose to acquirers. If there are compelling reasons for individual trusts to be interested in taking over others, this does not mean that such activity will necessarily be a success, or mitigates the very real risks for those involved. The question remains what have we learned, and what will be different, in relation to the next wave of takeovers compared with the mergers of the past?

12 Christensen, C., Alton, R., Rising, C. and Waldeck, A. (2011), "The New M&A Playbook", *Harvard Business Review* March.
13 The King's Fund (2011), *The future of leadership and management in the NHS.*

The next wave of takeovers will be different

> "NHS foundation trusts benefit from increased freedoms compared to NHS trusts, with scope to raise finance, undertake transactions such as mergers and acquisitions and make investments.
>
> Foundation trusts may consider entering into transactions in order to, among other things, help improve the quality of services, create greater choice for the public or improve the personalisation of services."[14]

In the private sector the decision to merge, acquire, or seek to be acquired has generally represented a specific, strategic response to the market conditions within which organisations find themselves operating, a response driven by those organisations themselves. For better or worse, such organisations live or die on the basis of their strategic decision making.

The same cannot be said for parallel activity within the UK health sector. In this context, successive administrations have sought to address issues of performance and supply in the acute sector through the centrally directed pursuit of hospital mergers within given areas. Hospitals have therefore been run as large, important organisations whose strategy has nonetheless been principally determined externally, by government. Leadership teams may be unaccustomed to taking strategic decisions themselves and indeed often, when they have been forced to take such decisions historically, they have seen them overturned by external intervention. They are subject to restrictive employment practices, meaning that it may be relatively difficult to change the staff group to fit new requirements, and regulated to a level that reflects the life-and-death nature of what they do.

Despite the lingering perception of the public sector as relatively static, most health organisations have nevertheless significant experience of organisational change. They know it to be a risky and painful process, with unpredictable results. And yet there are few changes more challenging to accomplish than merging with another organisation, particularly when (as is likely to be the case in mergers in the acute sector) there is a significant overlap, at every level, in core business operations. In the past two years, Monitor has overseen only six "significant" transactions (those involving a change of income greater than 25 per cent of the Foundation Trust involved).[15] Beyond the transfer of community services, the sector has seen very little recent takeover activity.

The growth of Foundation Trusts nonetheless represents a historic break with previous models of M&A activity within the sector, and a corresponding opportunity for the future.

The autonomous nature of Foundation Trusts means that future takeover activity, if it is to occur, will be driven by the organisations themselves. The "market conditions" which drive private sector M&A – the opportunity for growth, the threat of contraction – are more present now within the health sector than at any time in the past 20 years. For those organisations which may be underperforming or unable to achieve a viable level of size independently, there is as much a requirement to take control of their own destinies as for those which may enter into the market for acquisition. And if supported correctly, it will not just be the starting point but the outcomes themselves that will be very different in the future as well.

The successful takeover

> "The best integrators recognise the need for urgency, rather than planning, in integration... success is determined largely by how quickly a common mindset is created"[16]

As part of their study into global M&A deals, KPMG interviewed 107 senior executives directly involved in those deals to identify six determinant "keys" to success:

- robust evaluation of the business fit;
- integration planning;
- due diligence before any deal;
- management team selection;
- resolution of cultural issues and;
- effective communication to stakeholders including employees.[17]

14 Monitor: http://www.monitor-nhsft.gov.uk/information-nhs-foundation-trusts/transactions. Accessed 14 September 2012.
15 Interview with Richard Guest, 1February 2012.
16 Hinterhuber, A. (2002), "Making M&A work", *Business Strategy Review*, Volume 13 Issue 3, pp. 7-9.
17 KPMG (1999), *Unlocking shareholder value: the keys to success*.

For those involved in such activity within the NHS, each of these factors has significant part to play. The best trusts may have a good idea of their strengths and weaknesses, but in many areas performance information (particularly in relation to quality and viability of individual clinical areas) is lacking. There is a requirement for trusts, whether they are seeking to takeover or be taken over, to ensure that they have established credible and transparent baseline data to support their own and others' decision making.

Integration planning has often extended little beyond the initial amalgamation of organisations and back office functions. Ensuring that the right management team is in place has taken second place to minimising presented disruption of the integration process; a takeover has often been more comfortably described as a merger of equals, creating confusion around the nature and direction of the changes required. All of this can result in either a deferment of radical change or the dissemination of conflicting messages across the organisations involved.

Yet whilst it would be easy to blame any one factor for the failings of historic attempts to merge trusts, for example a failure of due-diligence before the merger or of integration afterwards, the reality appears more complex.

Success depends on effective management of the end-to-end process – of the creation of a "common mindset" around what is important, and how it will be achieved – from the earliest stages to the ongoing running of the new organisation, once integration is completed. "No matter how compelling the business case... acquisitions inevitably run into difficulties post merger. Key people leave, processes break down, information systems get tangled, and customers grouse. Problems can pile so fast that even the best deals can quickly become undermined".[18]

Whilst it might seem safer to plan for small changes, gradual synergies around management and the back office, the danger is that the process of integration becomes an excuse for not doing the very things that made the takeover a compelling proposition in the first place. This means delivering the big changes, those that affect the core way in which hospitals provide healthcare outcomes, and doing it well.

For takeovers to be effective, they will need to be a disruptive change, and this disruption is something that few organisations in the public or private sector have done well in the past. There are nonetheless a number of reasons for optimism that hospitals can embrace such changes in the future.

The example of the management outsourcing of Hinchingbrooke Hospital by Circle has generated much interest and comment, and has direct relevance as discussed later in this pamphlet, but remains a relatively isolated case for now.[19]

In relation to NHS takeovers, whilst there are differences between trusts, not least in terms of performance, there are also similarities; the cultural issues of assimilation, most often cited in the failure of mergers, genuinely mitigated by the fact that there is still a strong, common ethos across the NHS.

An executive board member of an acute trust might legitimately say of another: "There might be four miles difference between us, but there is two decades in terms of culture and practice"; but for those with practical experience of working both within and outside of the NHS, the similarities of culture if not of practice are just as apparent.[20] The cultural challenge is if anything greater for hospital trusts which have already taken on the challenge of Transforming Community Service and integrating with community providers, than for future mergers with fellow acute providers. In the acute sector, the organisations that emerge from takeover processes should be better placed to innovate, but in the first instance these are mergers of similar institutions delivering similar services.

The first challenge for such organisations is less one of bringing together different technical or business capabilities to produce something entirely new, but of ensuring that existing best-practice is effectively disseminated across the organisations involved. Bringing this all together requires effective leadership and management, and anything which is not understood in the context of a takeover of one organisation by another, to their mutual benefit, is unlikely to succeed. However, simply having a good organisation take over a failing one does not guarantee success. It is critical that cultural differences do not become an excuse for the failure to work together; and that effective engagement, including patients and clinicians, is recognised as fundamental to the success or failure of new models of care. We have two case studies of

18 Harding, D., Rovit, S. and Corbett, A. (2005), *Three Steps to Avoiding Merger Meltdown*, Harvard Management Update.
19 NHS Midlands and East (2012), "Hinchingbrooke hospital and Circle start their historic partnership", 1 February.
20 Fulop, N. et al (2002), "The process and impact of NHS trust mergers: a multi-centre organisational study and management cost analysis", *British Medical Journal*, 325:246.

takeover within the NHS; one is new but widely regarded as successful, the other is problematic. They both provide important lessons for organisations contemplating either being taken over or taking over.

We also have a case study from the private sector, WPP, a well-established example of a group that has applied the key principles identified in relation to successful takeovers that have realised rather than just consumed value principles which are applicable to and dovetail with the health experience as well, particularly in terms of balancing scale and local flexibility.

Case Study: Basingstoke and North Hampshire NHS Foundation Trust and Winchester and Eastleigh Healthcare Trust

The background

Hampshire Hospitals NHS Foundation Trust was established on 9th January 2012, bringing together Basingstoke and North Hampshire NHS Foundation Trust with Winchester and Eastleigh Healthcare Trust.

Mary Edwards, the Chief Executive of Basingstoke and North Hampshire who with her team has taken over the management of the combined Trust, recalls that there had been "talk for many years" about the potential for a merger.[21] However, the real focus began around 18 months before the takeover, at which time it became clear that Winchester and Eastleigh were unlikely to make it to Foundation Trust status on their own.

The local Primary Care Trust worked with local GP commissioners and other partner organisations to consider options, with the consensus emerging that acquisition by an existing FT represented the best way forward. However, when Basingstoke and North Hampshire FT expressed interest, the decision was equally the product of over a year of its own internal work in understanding its future options.

Basingstoke and North Hampshire FT was at the time financially sound, but, as a medium-sized district general hospital serving a population of 280,000, at significant risk in relation to sustaining its acute services.

With a desire to continue to develop in areas such primary angioplasty, stroke thrombolysis, major trauma and specialist surgery, the FT identified a need to grow the population it served to at least 500,000 – allowing it to sustain the breadth and depth of medical staffing required for 24x7 rotas and to deliver sufficient quality and capacity in key skills. Having evaluated its options, including looking at the complexities of competing to secure population in the face of significant entrenched loyalties to other local hospitals, the takeover of Winchester and Eastleigh presented a genuine strategic opportunity.

Yet whilst there were potential benefits from integration for both organisations, this was very much just the start of the process. Basingstoke and North Hampshire commissioned external advice in areas such as finances, estates, contracts and governance as part of their own due diligence, providing both their own trust board and Monitor with a structured view of the potential risks. Winchester and Eastleigh had been receiving several million pounds of bailouts from commissioners every year. Whilst some merger synergies were expected, there was a need to get in place an overall clinical model and mix that was sustainable, as well as to secure short term help financially to manage the transition.

A new clinical model

At the heart of the business case was the new medical model. Led by Basingstoke and North Hampshire's Medical Director, this involved a series of bilateral meetings by speciality area across the hospital sites, generating detailed information on clinical workforces, finances and governance. With local GP leaders engaged in the process, a 3-tier model was developed focused on locating the right services in the right setting, including:

- Community and primary care, consulting and diagnostic services;
- On each of the main hospital sites: elective, emergency medicine, maternity, elderly and chronic disease management;
- Co-located, a smaller number of specialist services, including primary angioplasty, major trauma, and stroke care.

The result was a five year business plan predicated on Trust operations being solvent from day one. The plan was reinforced through active engagement with staff, governors, the public, press and local politicians, led by the Chief Executive and with a small working group of the local Health Overview and Scrutiny Committee helping to guide the process.

21 Interview with Mary Edwards, 14 March 2012.

Making the merger a reality

At the advent of the merger, cultural differences between the two Trusts reflected both differences in local populations and differences in history.

The Royal Hampshire County Hospital in Winchester dates from 1868, sited with advice from Florence Nightingale and granted its Royal title by Queen Victoria; Basingstoke District Hospital was opened by Princess Alexandra in 1975. In recent years, Winchester and Eastleigh Healthcare Trust had suffered from multiple leadership changes and financial difficulties, with a commensurate effect on the morale of the organisation as a whole; in contrast, Basingstoke and North Hampshire Hospitals NHS Trust was financially stable, led by the same Chief Executive since 2003.

The process of bringing these organisations together was always going to be a tough one, the more challenging due to the need to continue to deliver core "business as usual". However, as the Chief Executive of Basingstoke and North Hampshire and now of the combined Trust Mary Edwards relates, a number of key steps helped ensure developments progressed to plan.

There was agreement with trade unions to ensure much of the re-organisation of personnel was completed prior to the launch of the merged Trust, with all key managers in place by Christmas 2011. Redundancies occurred, and efforts continue to help bring together clinical staff, but the Trust has already generated £8 million in back office savings through rationalisation and contract consolidation, and is now engaging medical staff as a group in the delivery of broader cost improvements. The senior team at Basingstoke and North Hampshire was kept together and intact throughout the process, and is now responsible for the combined Trust as a whole.

As Mary Edwards notes: "You have to be doing it for the right reasons". The Trust never expected the integration of the two organisations to address all of their individual challenges: "Just generating the merger synergies won't make you a successful organisation".

Case Study: Heart of England Foundation Trust and Good Hope Hospital

Good Hope

Good Hope Hospital serves North Birmingham, Sutton Coldfield and a large part of south east Staffordshire, with a total catchment population of 450,000. Originally a large Victorian House, purchased as a convalescence home in 1943 for the sum of £5,000, Good Hope had been developed and expanded over six decades to become a District General Hospital providing Accident and Emergency, acute, general medicine and specialist services. However, by April 2006 the hospital had also accumulated an annual deficit approaching £20 million, based on a turnover of just over £100 million; its own board judged that it was "no longer financially viable".

A takeover was not the first solution considered. In fact in August 2003 Good Hope had signed an agreement with Tribal Secta, establishing the NHS's first franchise management arrangement, with Tribal pledging "to work with staff to ensure Good Hope Hospital NHS Trust is a top-performing, three-star NHS trust by the end of its initial three-year franchise". Unfortunately, the results failed to match these aspirations. The contract was terminated early in December 2005, amidst criticisms by external auditors and a significantly worsening of the deficit.[22]

Acquisition

Heart of England NHS Foundation Trust (HEFT) initially became involved with Good Hope in November 2005, under an interim management arrangement supported by the local Strategic Health Authority. This saw Dr Mark Goldman, then chief executive of HEFT, became chief executive of Good Hope, with a number of his senior executive team also taking on management positions across the two organisations. Whilst the initial aim was to support Good Hope in becoming an independent Foundation Trust, in 2006 Good Hope's board took a unanimous decision to seek a merger "with a larger and more stable organisation". HEFT was asked to consider a formal takeover.

HEFT at the time was a large, well-regarded, financially-sound Foundation Trust, perceived to have the capabilities and scale to be able to absorb and address the issues at Good Hope. Formed itself from a merger between Birmingham Heartlands NHS Trust and Solihull Hospital in 1995, HEFT had achieved Foundation Trust status in April 2005. It had been voted one of the Top 10 Places to Work by the *Nursing Times* in 2005, and Acute Trust of the Year in the 2006 *Health Service Journal* Awards. HEFT's senior team had been directly involved in the running of Good Hope for a year prior to the take-over process commencing, potentially the best possible form of due-diligence any organisation could have undertaken.

Following an extensive three month public consultation with broad support for the move, HEFT took on the assets and liabilities of Good Hope in April 2007 under a Transfer Order signed by the then Secretary of State, Patricia Hewett. In an article in the *Financial Times* entitled "Trust takeover of failed hospital shows way forward", Hewitt explained that such takeovers "will not be the solution in every case", but "may well be the solution in some cases".[23] The deal was covered by the BBC News as a "landmark merger", Health Minister Andy Burnham noting that the Heart of England trust with its "excellent" financial track record was well placed to address the challenges at Good Hope.[24]

Simon Hackwell, who joined HEFT as programme director for the takeover, remembers the novelty of the process at the time.[25] As the first acquisition of a Hospital Trust by a Foundation Trust, there was no transaction manual, no established practice to guide the process. With support from Monitor and HEFT's own financial and legal advisors, there was a strong encouragement to take a commercial approach to the acquisition – "valuing" Good Hope – with less focus on the potential future configuration of services, or the cultural challenges ahead. The acquisition was described as being similar to a "Class 1 stock exchange commercial acquisition", recalls Hackwell. Although "it was not exactly clear who the vendor was", in the end a deal was negotiated with the SHA for HEFT to take on Good Hope in exchange for both transitional funding and a conversion of £17 million of historic debt into long term, low-interest public dividend capital.

22 European Services Strategy Unit for the Patient and Public Involvement Forum East Birmingham (2006), *Good Hope Hospital and the Heath Care Market,* November.
23 *Financial Times* (2007), "Trust takeover of failed hospital shows way forward", 2 April.
24 BBC News (2007), "Landmark hospital merger approved", 30 March.
25 Interview with Simon Hackwell 11 June 2012.

A challenging integration

Post-acquisition, HEFT embarked on a rapid integration programme focused around back-office and support services, and senior management. Hackwell notes how integration of IT, finance and governance functions had gone well, with continuity of provision being maintained and savings being made. However, within a year operational performance issues began to come to the fore. HEFT found itself in breach of its terms of authorisation in areas such as A&E, red-rated by Monitor on governance, and with its board being summoned to meet the regulator.

Hackwell notes that there was a strong focus on getting the financial situation under control, but that "we took too much power away from the clinicians at Good Hope". For a hospital with a history of "learned helplessness, a feeling of being disempowered, done to", this proved particularly damaging to any chance of improving day-to-day clinical services. When things started to go wrong, "we didn't expect – and nor did we receive – any help", says Hackwell. "But Monitor and the commissioners need to give Trusts time to turn things around. I doubt if you can do it in less than three years. Troubled hospitals didn't get into trouble overnight. Arguably it took us five years".

There is now an explicit provision in Monitor's Compliance Framework to cover this situation – described in Appendix F of the 2012/13 Framework, it states that: "In order not to discourage NHS foundation trusts from undertaking transactions with short term negative implications for Monitor's risk ratings, NHS foundation trusts may apply for investment adjustments." However, from 2007 HEFT and Good Hope were rated as one organisation – with issues of poor performance exposed in the local and national press, and the reputation of HEFT as a whole put on the line.

Outcome

Despite the challenges of the last 5 years, the feeling at HEFT is that ultimately the pain has proved worthwhile. After a period of tight central control, transforming management, financial and regulatory arrangements at Good Hope, there has been an increased focus on local autonomy. The Trust now operates as a group of semi-autonomous business organisations on a "hub and spoke" model, with corporate, back-office and regulatory services centralised and local MDs concentrating on managing patient-facing services. A degree of specialisation has begun, with Solihull Hospital moving towards becoming an integrated care organisation with local social and community services, Heartlands developing into a more complex, teaching hospital, and Good Hope continuing as a District General Hospital, working with Heartlands in areas such as Paediatrics and A&E to ensure effective, high quality coverage.

Hackwell acknowledges that the environment is harder now – from a financial perspective, there were strong incentives for HEFT to increase its market share, and the combined organisation was able to rely on growth to address some of the legacy financial issues. In future, Hackwell believes the incentives for FTs will have to change, and in February 2012 HEFT announced that they would not be pursuing the takeover of George Eliot Hospital Trust in Nuneaton, citing other "strategic priorities". However, Hackwell believes that as a result of the takeover of Good Hope and the subsequent integration process, HEFT has become a better organisation. "Clinically we are stronger and in other areas such as research and education we have also moved up many levels. Attracting talent and investment are easier because of the size of the organisation. We now run the largest obstetric service in the country – that's a big pull for many clinicians who want to sub-specialise or do research."

There is a concern that the negative publicity around HEFT's experiences may put others off. Hackwell suggests encouraging franchise arrangements by FTs, allowing reporting as separate organisations and addressing performance issues over a period of several years, such as the ten years that Circle have secured at Hinchingbrooke. He stresses that it is possible to get through the takeover process successfully. "It just takes time, and determination".

26 Monitor (2012), *Compliance Framework 2012/13.*
27 *Health Service Journal* (2012), "Heart of England pulls out of mooted George Eliot takeover", 21 February.

Case Study: WPP

Wire and Plastic Products Plc was founded in 1971 and, until a group of investors led by Martin Sorrell acquired a controlling stake in 1985, was as its name suggests in the business of producing and distributing wire and plastic products.

The takeover of the original Wire and Plastic Products was the first of a series of acquisitions which have led to WPP becoming the world's largest communications services group, incorporating research, advertising, public relations, digital and healthcare communications. In 2012, WPP Group had 158,000 people working in over 2,500 offices in 108 countries.

Few NHS Chief Executives aspire to become the next Martin Sorrell, but the success of WPP in both acquiring and operating the organisations which make up its global business reflect a number of key principles, no more specific to its sector than Wire and Plastic Products was at its inception.

Sorrell had been Group Finance Director of Saatchi and Saatchi from 1977 to 1985 and had sought to capitalise on this experience to create a major new multinational marketing services company that would respond to changing market demands and technologies. Starting with "the unloved, fragmented areas of marketing services: areas of promotion, design services, what were crudely called 'below the line' services", WPP under Sorrell acquired 18 companies in just 18 months. WPP quickly went on to complete a series of further takeovers including in 1987 the JWT Group, a US media advertising agency that found itself in financial trouble, effecting a significant improvement in profitability over the following three years.[28]

By 2011, WPP comprised 294 companies. Ghobadian and Regan note that: "The common wisdom suggests that in creative industries size adversely impacts on creativity; therefore, large size presents a disadvantage", but that "WPP has proved that this is a myth", with a structure designed to allow flexibility within individual business units whilst leveraging economies of scale and breadth of talent across the group as a whole.[29] During the last two decades the group has faced significant challenges, but has also shown significant resilience in the face of market downturns and strong net growth across this period.

Martin Sorrell has himself commented on a number of occasions on how he feels WPP's approach has enabled it to use acquisition to support its growth and commercial success.

Whilst asserting that "there is no such thing as a merger – they are all acquisitions" Sorrell has highlighted the different ways that WPP seeks to integrate newly acquired organisations.

A key aspect of this has involved developing a shared, positive culture across the group. "Many now use the word culture to justify not doing what you want them to do. They say, 'It's not in their culture', when it means that they really don't want to do it."

"As we develop experience of the company we may integrate it into different parts of the organisation. There is no generic time span for integration – this can range from days to years depending on the acquired company". Separate organisational identities have often been maintained, whilst bringing together multi-disciplinary teams from different organisations to work on client opportunities. Changes in management in the organisations being acquired are often limited, rather than wholesale.

Such developments have not always been straightforward. "We had a co-ordination problem with two people in one room 25 years ago", said Sorrell. "Today you can imagine the issues dealing with 140,000 people where we don't even have control of some of the businesses". However, Sorrell suggest a key lesson is that "as you grow you have to try and keep it small".[30] In practice, for district general hospitals as much as for global communications agencies, this means balancing the ability to leverage the additional scale and resources that comes through being a larger organisation, with not losing the customer focus, the commitment or the flexibility of a smaller one.

28 Ghobadian, A. and O'Regan, N. (2011), "Building from scratch a marketing services giant by acquisition: Case study and interview with Sir Martin Sorrell, Chief Executive of WPP", *Journal of Strategy and Management* Volume 4 Issue 3, pp.289 - 300.
29 Foster, G., vin Bismark, M. and de los Heros, B. (2010), *Global Entrepreneurship and the Successful Growth Strategies of Early-Stage Companies*, Executive Cases: WPP, World Economic Forum, November, p. 256.
30 Foster, G., vin Bismark, M., de los Heros, B. (2010), *Global Entrepreneurship and the Successful Growth Strategies of Early-Stage Companies*, Executive Cases: WPP, World Economic Forum, November, p. 255.

5

The impact of the Health and Social Care Act on the policy architecture

The passage of the Health and Social Care Act from its conception in July 2010 as a White Paper to its birth as an Act in March 2012, involved a much greater range of influences than normally goes into a legislative process. We need to understand the policy drivers behind the Act if we are to better understand the new architecture within which mergers and acquisitions in the NHS will take place.[31]

This is far from easy. For example, the policy was initially established with some intention of increasing the power of markets to drive change within an NHS liberated from central control. Such a policy, if allowed to fully develop, would have a powerful impact on the way in which mergers and acquisitions would take place within the NHS. If a market were really driving change, hospitals would fail and be allowed to fail. Those hospitals that were failing would be seen as important in teaching the need for radical improvement in the others. Markets teach organisations to learn from and thrive on failure as much as they learn from and thrive on success. In the genesis of the Act up until April 2011 it was expected that these market pressures would become an important part of the new architecture.

The White Paper and the Act have abolished the main NHS organisations that were responsible for planning major hospital reorganisations – the Strategic Health Authorities. These ten regional organisations, in representing the owner of most hospitals who were not Foundation Trusts, have been the major driver and organiser of mergers. This was one of the reasons that they were so unpopular with MPs, since they were perceived as bringing hospital change into the NHS without any local political accountability.

However in the summer of 2011 there were strong public and Parliamentary arguments against the power of the market in bringing about change in the NHS. As the Health and Social Care Bill was amended, the power of markets was diminished and the emphasis on central planning re-emerged.

Market forces will now be a much less significant driver than the continued nature of regional and central planning.

The new architecture has four major forms of drivers that will have an impact upon the policy and practice of mergers and acquisitions: first, the nature of provider organisations themselves; second, the role of commissioners as drivers for change; third, the national framework within which this will occur, with the power of three national institutions in particular – the National Commissioning Board; the development of the new Monitor and the National NHS Trust Development Authority; and fourth, and most difficult to discern, the impact of local party politics on the development of a national architecture. And all of this is wrapped around with the impact of democratically elected politicians upon this process of change.

i. The nature of NHS Trusts

Some NHS providers will thrive in the difficult economic environment – those organisations that are better at driving better outcomes and better value for money. They will use the greater pressure on cost to improve their position within their localities and will drive cost and clinical improvement.[32] Nearly every organisation that thrives will be a NHS Foundation Trust and will have been used to taking responsibility for running its own affairs for some time. Even though they will have learnt to run their business during times of growth, they have learnt to take responsibility and will work through difficult economic pressures more effectively than others.

There are other trusts, most of which are not Foundation Trusts, which have not been able to create a sound economic basis for their future at a time of growth and are not very likely to be able to do so at a time of economic difficulty.

The new NHS architecture separates the Foundation Trusts and non-Foundation Trusts even further. It is clear that if trusts cannot become FTs within a specific period the new architecture will expect them to undergo drastic change. As of September 2012 this action has not been specified, but simply carrying on as

31 Timmins, N. (2012), *Never Again*, The King's Fund.
32 Pike, C. (2012), *Inside the black box: How competition between hospitals improves quality and integration of services*, Co-operation and Competition Panel Working Paper, July.

before outside of Foundation Trusts status is not possible. One of the outcomes for those trusts that will neither become FTs, nor will be allowed to continue as they are, will be the increased pressure to merge or be taken over.

ii. The nature of commissioners

One of the aims of the new Act is to empower new people to carry out new ways of commissioning services for NHS patients. The new architecture empowers two sorts of new commissioners – GPs at a local level through clinical commissioning groups (CCGs) and professional commissioners at a national level through the National Commissioning Board. The commissioning decision that may have an impact on changing the configuration of local hospitals sits with local CCGs.

One of the main changes brought about by the Act will be to try to empower local GPs to lead these new commissioning organisations. The idea behind this is that GPs will have a clearer clinical view of what needs to be commissioned and a better clinical understanding of the outcomes of the services that are provided by their hospitals. The expectation is that GPs will want to commission new services that move some care which has traditionally been carried out in hospitals out of hospital care into the community. The outcome of this movement will be to take some lines of business that have traditionally been carried out within the hospital (a large number of patient appointments and a lot of long term condition care) out of hospitals. The loss of this income stream is going to increase the pressure for organisational change.

It is therefore likely that local commissioning decisions will increase the pressure on hospitals. Alongside this economic pressure for change, the new architecture places the main legal duty upon these CCGs to help organise what has up to now been called the reconfiguration process. It will be the CCGs, alongside the new organisation within local government, the Health and Wellbeing Board, whose job it will be to lead these changes locally.

Many people who have been involved in the reconfiguration of local hospitals within the current NHS architecture believe that CCGs and Health and Wellbeing Boards will not cover large enough areas to be the main agents behind the reconfiguration process. Critics say that they are not strong or big enough to do the heavy lifting required to make these difficult changes happen. This will especially be the case in many urban areas where city regions will have a large number of local authorities covering a single hospital system that will need reconfiguration.

iii. The national organisations in the new architecture

There are two important new national NHS quangos, and another national quango has substantial new powers added to its existing powers.

a) The National Commissioning Board

The National Commissioning Board (NCB) has been set up to carry out three tasks. First, the Department of Health will no longer be the national organisation that runs the NHS. Much of this power moves to the NCB which is a separate legal entity from the Department. Once a year the Secretary of State will develop mandate with the NCB where he will hand over around £80 billion and tell the NCB within certain parameters to commission health care. It will then be the NCB's task to carry out the instructions within this mandate.

The NCB itself will directly commission specialist hospital care. It will nationally commission specialist health care where the local CCGs simply do not have enough cases of a disease within each locality to have the expertise to do this. This annual NCB spend is expected to be an estimated £10 billion and will have a considerable impact upon the configuration of national and regional hospitals. Whilst smaller hospitals do not have very much business from rare conditions, there will be some teaching hospitals that will gain over a third of their income from this national specialist commissioning. Indeed, one of the likely outcomes of national-level commissioning of specialist care is that the new medicine that treats very rare diseases will be concentrated in fewer hospitals, taking business from some hospitals and moving it to specialist centres. In this way, the NCB as well as local CCG commissioners will be increasing the economic pressure on some hospitals to radically reorganise.

The NCB will also performance manage the local Clinical Commissioning Groups. Throughout the summer of 2012 it has been running an authorisation process to determine whether new CCGs are capable of carrying out their new tasks. If it decides they are, then the NCB will pass on the money and the responsibility to CCGs for local commissioning. The NCB will have four regional offices – one in the South, one in London, one in the North and the other in the Midlands and East. As we suggested above, CCGs may

be too small to carry out the process of major hospital reconfigurations, so it is likely that the regional offices of the NCB will be the major drivers of large-scale change.

b) The NHS Trust Development Authority

The NHS Trust Development Authority is another new quango, which will have a vital role to play in changing the organisation of NHS hospitals. When Foundation Trusts were first established in 2004, the aim had been to make that organisational model much more autonomous than existing NHS trusts. The aim of all Governments then and now has been to move all existing NHS provider trusts down a development "pipeline" so that they can become Foundation Trusts. Under the old NHS architecture, it was the regional Strategic Health Authorities that were responsible for developing NHS hospitals trusts down that pipeline to Foundation Trust status.

The new architecture abolishes SHAs and therefore all NHS trusts that are not Foundation Trusts by 1st April 2013 will move from the control of the SHA to the NHS Trust Development Authority. This change of control is an important legal issue. Non-Foundation Trusts are organisations that are owned by the Secretary of State. One of the major controversies caused by the creation of Foundation Trust status was the fact that the new organisations (Foundation Trusts) would no longer be owned by the Secretary of State, but the ones that remain behind would be. The NHS Trust Development Authority will carry out the development function on behalf of the owner – the Secretary of State.

For the purposes of the policy and practice of the takeover of non-Foundation Trust hospitals, it is the NHS Trust Development Authority that will be key. It is likely that from April 2013 the Development Authority will have about 100 NHS hospital trusts that have not become Foundation Trusts. Whilst the existing SHAs have been tasked to draw up development plans for all of these trusts to become Foundation Trusts, the reality is only a few of them will have the economic or managerial capacity to make that transition. It will be the task of the Development Authority to "develop" these trusts into viability in a wide variety of ways.

Although there remains much to work out and define, it is difficult to see how the Development Authority can achieve the outcome of viability without taking a systemic approach to mergers and acquisitions. If the NHS carries out its traditional approach to mergers and simply lumps failing hospitals together to make a bigger failing hospital, this will not provide those NHS hospitals with a sustainable future.

However, while much of the policy framework that this pamphlet advocates will have to be carried out by the NHS Trust Development Authority, the organisations which will need to be actively involved in the takeover will not be under the Authority's control; the Foundation Trusts are separate organisations that are under performance review by Monitor, and the private sector hospitals will be able to make their own decisions. Although the NHS Trust Development Authority has control of the trusts to be taken over, they are at the mercy of other organisations to do the taking over.

c) Monitor

The third national agency is Monitor. Monitor was set up in 2004 in order to provide an authorisation process for those trusts that wanted to move to Foundation Trust status. This was a tough process that involved two tests. First, were the institutions viable as separate institutions? Second, were their Boards capable of taking on that autonomy? Monitor has succeeded in assessing over 50 per cent of the trusts into Foundation Trust status and it has worked hard to maintain the standard of the assessment.

However, the growth in the number of Foundation Trusts has meant that Monitor has been forced to take on another role. Once a hospital is a Foundation Trust it needs to have its financial plans and viability managed, and Monitor has that role. Such performance management can be carried out with a very light touch for as long as the hospital remains viable and thriving. However, as the NHS finances tighten it has become harder for Foundation Trusts to ensure their financial viability. In the summer of 2012 there were 18 Foundation Trusts under "special measures" (i.e. they had fallen behind their agreed financial plans with Monitor). It is possible that the number of struggling trusts that need to be taken over will grow to include a number of Foundation Trusts.

Under the 2012 Act, Monitor has been given a range of new functions in addition to the assessing of NHS providers for Foundation Trust status.

First, all providers of NHS-funded services, unless exempt under the Secretary of State's direction, will be required to hold a licence from Monitor. It is under this regulation that Monitor will continue to regulate Foundation Trusts, which will require this licence to practice. Monitor will develop a version of the licence

for Foundation Trusts that contains extra conditions relating to governance so that it can continue its oversight role. Obviously if Monitor withdraws its licence to practice then a provider can no longer provide NHS funded services.

Second, Monitor will regulate pricing and will be in a position to drive change through its pricing regime. Since it will be setting the price for nearly all of the income that NHS provider trusts obtain, Monitor will have a significant impact upon the organisations' sustainability.

Third, Monitor has a duty to enable integrated care. Even though it will be the responsibility of commissioners to develop and commission better integrated patterns of care, Monitor will also have the general duty to enable the integration of health care services with health related or social care services.

Fourth, Monitor has a duty to safeguard choice and competition and is taking over the existing Co-operation and Competition Panel. The existing principles and rules of competition will be incorporated into the licence conditions mentioned above. In other industries and services, mergers and acquisitions often infringe the rules on competition, so this part of Monitor's work is certain to have a big impact upon any policy and practice of competition.

Fifth, Monitor has a new duty to ensure the continuity of services for NHS patients. It will have powers to protect access to essential services and enable them to continue in the event of a provider becoming unstable. One of the great anxieties that the public have is that big changes in the services provided by their local hospitals may leave them abandoned. There is no one – apart, nominally, from the Secretary of State – whose task it is to ensure that they continue to receive NHS services. If the public believed that Monitor would really carry out this task, it could take some of the sting out of the political rows about mergers and acquisitions.

As the Health and Social Care Act was going through Parliament, commentators often asked who, within the new architecture, was going to be responsible for making the difficult large decisions about hospital changes. Our outline of the proposed architecture demonstrates that there are a number of organisations that have a role both locally and nationally. While the wide range of different players may mean that there will be plenty of pressure on failing hospitals to change, it also results in a diffusion of responsibility. It may be that the confusion between different roles and responsibilities will make it unclear whose responsibility it will be to act.

iv. The role of politics

The reality of democratic party politics in relation to the NHS will play a big role in how this architecture will work. Closing a ward or a service in a local hospital triggers a passionate campaign to "save our hospital". Most local politicians are terrified of being on the wrong side of such a campaign. The accepted wisdom is that it is impossible for a sitting MP to do anything but support the campaign. The belief is if they were to try and point out the rationale for the change – better quality care or more sustainable services – their voice would be overwhelmed by the local passion against change. And the fear is that one of the opposition parties, or a campaign candidate, will successfully stand against them and win.

This belief about the politics of campaigns against change in hospital services is almost universal. There is a strong belief amongst elected politicians that there is almost no place to stand if you want to be re-elected except on the side of those arguing for the past.

The argument from an elected politician goes: if my hospital is radically changed, there will be a strong public campaign against it. If I do not support that campaign I will lose my seat. Therefore I have to stop you from making radical changes to my hospital or I will lose my seat. For a politician this is a strong motivation and has led to Cabinet Ministers in this Government and the last who supported NHS reform coming out on the streets to argue against that reform when it tries to change the local configuration.

Unless Government makes it clear that hospitals are allowed to fail, the hospitals in question are unlikely to carry out the difficult change management tasks. Unless there is a threat of closure, the leadership of the organisations does not face up to the change. If every failing hospital believes that its local elected politicians will stop its closure, then they will avoid going through the hard business of change.

If the NHS were better at initially engaging the public in the case for change in local hospitals, this would provide the elected politician with cover. If this engagement were to involve local clinicians playing a lead role, so much the better. In the next section we explore how important it is in addressing the future of failing hospitals to address the fears and aspirations of local clinicians and patients.

6

How to run a takeover that reconfigures services in the hospital, and how it is clinicians and patients who will make it or break it

Even if well executed, economies of scale arising from hospital takeovers are likely be insufficient to deliver a sustainable clinical and financial position for the trusts involved. As such, takeovers are not an alternative to the reconfiguration of hospital services, but are in fact likely to involve and require it.

A merger or acquisition creates organisational disruption and in doing so opens up the opportunity for positive change, but hospital trusts have been reluctant to press home the opportunity and often life in the merged entity has continued as before.

It is commonly held that reconfiguration, which the BMA defines as "the way in which services are delivered will change", will fail if it is primarily the brainchild of managers. The BMA, the Independent Reconfiguration Panel (IRP), the King's Fund and many commentators assert the importance of clinical and public leadership and involvement.

Strategic and business plans developed by NHS commissioners and providers invariably cite "clinical and patient engagement and involvement" as necessary and high priority features of their approach to change. The evidence nonetheless shows that efforts to do so often fall short, and that business objectives and improved performance outcomes are consequently not achieved.

A particular challenge with reconfiguration is that it potentially destabilises and threatens the deep-seated psychological contracts that many senior clinicians and local patients and carers have with the NHS. These threats have to be confronted in a way which offers a rational and evidence-based solution, but also acknowledges and addresses the very human fears and emotions involved. Livelihoods and lives will be affected.

Put simply, clinicians and local patients have the power to cause an attempted takeover to be abandoned. Equally, a lack of active participation will prevent the planned step change in outcomes and sustainability from being achieved.

A well-conceived takeover brings within reach the levers of real change and a sustainable future, but also demands a high order of leadership and skill to energise and engage all of the parties affected, and to forge a coherent solution from the diverse organisational, professional and personal interests in play.

It is therefore necessary to consider the implications of takeovers for clinicians and patients respectively, and here we suggest some practical steps which can be taken by the acquirers of failing hospitals to design and implement a reconfigured hospital or health system which delivers for clinicians, patients and managers involved.

Clinicians

The career of many NHS managers is turbulent and unpredictable – the average of tenure of a chief executive is currently less than two years. By contrast, once they have climbed the rank to consultant, the career and position of most senior doctors, in terms of power and authority, professional standing and working arrangements, can be remarkably stable and predictable, even when the name and organisational status of their employing provider organisation changes around them.

Relative to senior professionals in many industries who continue to change employer, job role and seniority into their 40s and 50s, senior doctors can currently expect to reach the top of the career ladder in their mid-thirties and retain this position for over 20 years, usually with the same NHS employer, often supplementing their hours and income with work in local private hospitals and clinics.

Hospital takeover can bring significant disruption to arrangements which doctors could reasonably assume to be longer-standing, whether they belong to the hospital being taken over or the hospital doing the taking

over. The BMA Good Practice Guide to Hospital Reconfiguration makes it clear that consultants "may be asked to change their job plan (including a potential drop in programmed activities), be asked to relocate, or, in extreme circumstances, be subject to a redundancy process".[33]

The right rational outcome of a takeover may be to break the hierarchy of existing clinical teams and create a shift in the balance of power between senior doctors. Consultants in a hospital trust being taken over may fear the perception or the reality of becoming professionally a second-class citizen, and worry that their clinical practice may be challenged and forced to change. In practice, when invited to work together to form a joint clinical team as part of a prospective merger of equals, it is not unusual for clinical teams to prefer to leave structures and locations intact rather than open up the prospect of a shift in power and authority.

A key professional concern of clinicians is likely to be disruption to carefully organised arrangements for education, training and research. Will the takeover result in a reduction in training opportunities for trainees and a drop in the number of trainees' posts? How will research and teaching be delivered in future?

Day-to-day, a takeover may disturb consultants' working arrangements and undo their carefully crafted routine. Hospital sites in merged organisations may be up to an hour's drive apart, whether in rural or busy urban locations, and regular sessions at private hospitals, currently neatly integrated into the work timetable, may be harder to accommodate. In some organisationally merged but not integrated hospital trusts consultants often keep working at one site and barely visit the other. The consequence for consultants may be increased out-of-hours and weekend working in order to ensure sufficient specialist cover across the sites involved.

Rules and protocols for hospital rotas and the composition of medical teams are a key piece of infrastructure in the drive to stop hospitals from failing, and there is already a challenge in the system to improve specialist cover at weekends.

We look to the medical establishment to play a leading role in developing and championing refreshed and progressive guidance on rotas and medical teams, thereby opening up more freedom for clinicians and managers to come up with workable local solutions. At face value, it may look and feel to clinicians that they have much to lose from hospital takeovers. How can clinicians best be engaged in the development of solutions such that, with some give and take, they share the benefits?

It is received wisdom that clinicians should lead change in the NHS, and there are increasing efforts to develop leadership capability alongside clinical skills. A very useful synopsis of the capability required and the associated challenges can be found in *Medical Leadership: from the Dark Side to Centre Stage*, the title of which illustrates a gulf between doctors and managers which can frustrate the pursuit of improvement within the hospital setting.[34]

In his 2008 Review, Lord Darzi wrote of an "obligation to step up, work with other leaders, both clinical and managerial, and change the system where this would benefit patients."[35] Building on this theme, a Medical Leadership Competency Framework (MLCF) was developed in May 2008 by a combination of the Academy of Medical Royal Colleges and the NHS Institute for Innovation and Improvement. The framework describes "the leadership competencies that doctors need to become more actively involved in the planning, delivery and transformation of health services."[36]

Efforts to develop leadership skills in this area are well-founded, and the MLCF bears strong comparison with equivalent products in high quality public and commercial organisations elsewhere. The best organisations use such products as a way to hold regular development conversations with their senior people, challenging them to a focus on leadership and adopt a disciplined approach to the measurement of progress. We know that driving adoption and sustained active use of such products is not easy and that many mature commercial organisations fail to do it. Nonetheless, the building of clinical leadership capacity in the planning, delivery and transformation of health services is key in dealing with failing hospitals, and this is a challenge to which local leaders and the profession need to rise.

What of incentives? Two private sector examples are worth noting, Kaiser Permanente and Circle, both of which combine the development of leadership skills with financial incentives.

33 British Medical Association (2007), *Hospital reconfiguration: Good practice guide.*
34 Spurgeon, P., Clark, J. and Ham, C. (2011), *Medical Leadership: from the Dark Side to Centre Stage.*
35 Darzi, A. (2008), *High Quality Care for All: NHS next stage review final report*, Department of Health.
36 Academy of Medical Royal Colleges and NHS Institute for Innovation and Improvement (2010), *Medical Leadership Competency Framework.*

Kaiser Permanente is an integrated managed care consortium operating in the United States. It combines the Kaiser Health Insurance Plan, which has more than nine million members; Kaiser Foundation Hospitals, with 37 hospitals and annual operating revenue of $48 billion; and the Permanente Medical Groups, which provide healthcare for the plan members. The Permanente Medical Groups are for-profit partnerships owned by the doctors who work in the Groups. By delivering high quality healthcare efficiently, Kaiser Permanente is able to attract patients and keep subscription rates sufficiently competitive. Partners in the Permanente Medical Groups benefit from the organisational reputation for high clinical standards and stand to share financially in any surplus generated up to a declared ceiling. Careful attention is paid to leadership and team working skills in recruitment and in collective decision-making about admission into the partnership. Partner retention is high, and applications for medical jobs, with the subsequent opportunity to be offered partnership, are highly oversubscribed.

Closer to home, Circle is an example of an "employee co-owned partnership", in which employees are incentivised to deliver high quality services and continuous improvement through the ownership of shares and a culture of engagement. Shares are allocated on the basis of people's contribution, or performance. At Hinchingbrooke Healthcare NHS Trust 1,200 of the 1,700 hospital staff were involved in 4-hour "partnership sessions" and the establishment of the change programme to make the Trust a "top ten district general hospital".

Studies of employee-owned business provide evidence that companies where professionals, managers and staff are shareholders and not just stakeholders compete favourably with traditional equity-based companies, and are more resilient and successful in tough times.[37] NHS Trusts and Foundation Trusts are clearly not constituted as employee-owned partnerships. However, the lesson from Kaiser, John Lewis and, potentially, Circle is that leadership and participation should not be skin-deep – reserved for the top echelon of clinicians – but should permeate deep into the organisation, at least to the level of clinical unit. Establishing what good looks like is helpful – where a high-performing trust has acquired a poorly-performing one, overall targets for quality and efficiency need to have been set – but in order to deliver real change, working-level clinical teams will have to make the hard yards.

There is no denying the importance of board level clinical champions as a demonstration of the organisation's commitment to drive through a takeover. However, this is about more than the medical or nursing director. The medical director is not necessarily the doctor with the most power and influence in the hospital trust, and fundamental changes imply a combination of breath and depth of engagement.

Let us now turn to the upside. What, from a clinician's perspective, should be the positive benefits of a takeover situation?

Of primary importance to clinicians is the delivery of safe clinical services. For the BMA, reconfiguration is acceptable when it is safe and maintains or enhances standards of care across a health economy. For the Royal College of Surgeons, the quality of care and the safety of the patient is the primary concern of the consultant during their treatment. At Hinchingbrooke, "no hotspots" and "zero harm" are the first headline objectives in the new vision.

Building a case for a takeover on clinical quality and patient safety provides a strong starting point. In many cases hospital trusts do not have the scale of population to provide sufficient flow of cases or sufficient specialist clinicians seven days per week to meet the recommendations of NICE and the Royal College on the scale of clinical operation required to deliver a safe service. The focus of regulators and, increasingly, of clinical commissioners on the obligation to deliver a safe service, as well as the increasing amount of information about outcomes available in the public domain, will soon bring service scale questions up the hospital trust's agenda.

For clinicians, safety is also a personal, reputational issue. The brand of a hospital trust is important when considering which institution will best further a clinical career. When positions fall vacant, clinicians will be more reluctant to join an organisation failing on safety, and this in turn can exacerbate a lack of specialist clinical coverage and accelerate the impetus to reconfiguration. At Queen Marys Sidcup, part of South London Healthcare Trust, services which were planned to relocate under reconfiguration proposals had to close in any case because vacancies remained unfilled and the board could not guarantee a safe service.

From a professional perspective, the combination of two hospital trusts through a takeover may bring opportunities for further development as a clinician. Where a trust with a strong tertiary service and

37 Matrix Evidence (2010), *The Employee Ownership Effect: A Review of the Evidence*.

research capability acquires a district general hospital serving a large neighbourhood population, both sets of clinicians may benefit. Those in the district general hospital may get the opportunity to develop more specialist skills and better access to research opportunities, and those in the acquirer will have the opportunity to conduct research and develop innovative practice with a larger catchment population base. In some cases it may be that a clinical department in the trust taken over is recognised as delivering a higher quality service, and the change may offer the chance for the clinicians involved to spread their influence more widely. Either way, if a hospital is failing on the quality and safety of its services, a takeover should enable the adoption of better clinical practice across the whole footprint of the merged organisation more quickly than would be achieved through incremental internal change.

Less grand, but no less significant is the impact of any takeover on the working hours of clinicians and where they go to work. Attention to best clinical evidence and travel guidelines will inform decisions about how many instances of each service there should be in a reconfigured service and where services might be located, but clinical evidence does not provide the whole solution.

Decisions about who works where and when should be the product of detailed logistics design and planning, taking in the make-up of clinical teams, the programming of rotas to enable seven day coverage, the use of buildings and the provision of information technology to optimise use of clinical time, reduce unnecessary duplication and provide electronic access to diagnostic results and patient records.

The quality of this process will depend on the calibre of operations staff and the quality of systems available. An acquiring trust may have strength in these areas. In return for flexibility, clinicians may benefit from logistically improved working conditions in future, where the scheduling of appointments and admissions works more smoothly and peaks in demand are managed to make the working day more predictable.

We know that many consultants spend a proportion of their time working in private practice and that this forms part of their individual logistics planning. Given the complexity of the logistical challenge in optimising a reconfigured model for all participants, we suggest there is a case for involving local private hospitals in logistics planning. Flexibility and engagement from all parties is more likely to enable a solution to be found which works sufficiently well for everyone.

A cornerstone of an optimised clinical service is the composition of the clinical teams required to provide safe coverage. With recent changes, such as the adoption of the European Working Time Directive and advances in technology, as well as the need to strengthen clinical presence in hospitals at the weekend, the Royal College of Physicians is looking to develop fresh guidance on this topic. This is urgently needed as increasing numbers of hospital trusts look to merge and reconfigure.

Patients

For many patients, local hospitals are at the core of the psychological contract between citizen and government. They are "the living embodiment of public services, they are deeply symbolic, they are even bigger than the NHS, they are the public's symbol of public services and a safety net."[38] As we have seen, it is possible to get elected as an MP on a ticket of defending a local hospital from closure.

Part of the deal is assumed by most people to be that the local hospital provides all necessary services for people's healthcare and that it should not be necessary to travel further afield for care. However, as demonstrated by the recent reconfiguration of stroke services in London, the diversion of patients from past district generals to one of four specialist hospitals has resulted in many lives being saved.[39] Before the changes, patients in London were going into one of 32 local hospitals without the facilities, medical or nursing expertise to be able to deliver the best hyper-acute stroke care. Now, patients are treated in just eight hyper stroke units, situated as close to patients as possible, and then transferred on to one of 20 local stroke units for ongoing rehabilitation.

Most towns in 1948 had a general department store on the high street as well as a district general hospital. Most small town department stores have now disappeared, and, while there is strong provision of convenience stores locally, retail customers are increasingly prepared to travel a good distance to a large town centre or out-of-town shopping mall to find stores with depth across the full range of goods. Consumers of NHS healthcare have not yet made this transition, but will need to do so for the NHS to provide economically what it knows to be high quality care.

38 Imison, C. (2011), *Reconfiguring Hospital Services*, The King's Fund.
39 Appleby, J., Ham, C., Imison, C., Harrison, T., Boyle, S., Ashton, B. and Thompson, J. (2011), *Improving Health and Health Care in London – Who will take the lead?*, The King's Fund.

The Coalition Government, like previous governments, is nervous about advocating hospital closures, but there is increasing talk in the media of the need for reconfiguration from local politicians, research institutes, the Royal Colleges and leading commentators. If the Government is to hold the line as increasing numbers of hospital trusts fail, a resetting of the psychological contract with the public – that local hospitals deliver the best quality – is a crucial communications challenge to meet.

However, the Government can only open the public's mind to the possibility that changes in local hospital provision may improve services. It is up to local leaders to make a strong case for local reconfiguration and to be transparent and engaged from the beginning. Increased public openness about failing hospitals should enable a stronger case for change to be presented, and if hospital trusts with a strong brand are involved as acquirers, public fears may be reduced more easily.

The Independent Reconfiguration Panel is responsible for scrutinising reconfiguration proposals on behalf of the Secretary of State and cites as a frequent finding inadequate patient and public engagement in the early stages of a reconfiguration process.[40] It is good practice to seek to understand from the start patients' fears and objections to a takeover and its consequences and address these explicitly and strongly.

The King's Fund's recent briefing on reconfiguration points out that local overview and scrutiny committees will understandably focus on access and transport when considering reconfiguration proposals, but are not required to take account of care quality or value for money.[41] It will be important that future scrutiny arrangements enable local decision-making to be rebalanced so that the right trade-offs can be made and a solution found which is clinically, operationally and financially sustainable. This means undertaking a number of practical steps.

The first is to create a sense of positive local vision which patients, politicians, doctors and nurses can rally behind, whereby a takeover is about building a distinctly new, better and distinctively tailored set of services for the locality, with a different clinical model, rather than simply about the combination of two legacy organisations or the downgrading of the failing hospital trust. The enterprise should be positively branded and the headline improvements in service quality which form the basis of the proposal should be clearly and repeatedly stated in plain and positive language.

The second is to make sure that the hospital trust leaders involved are brought to a detailed and shared understanding about current clinical, operational and financial performance such that the case can be built on sound fact. Hospital trusts are complex businesses, with multiple interdependent service lines and a patchwork legacy of practices, buildings and systems. Poorly performing trusts often lack the skills, infrastructure and data quality to develop a sufficiently comprehensive analysis of current performance and an understanding of the drivers of that performance. Potential acquirers are more likely to possess the necessary capability. A sound performance baseline, once established, can be used as the basis of the case for change and to demonstrate the benefits promised.

Our final suggestion is to develop an accessible model of how hospital services will look and work for patients and clinicians post the takeover, and to make early improvements to existing services which provide confidence that the new team in charge has the ability to deliver on promises made.

40 Independent Reconfiguration Panel (2010), *Learning from Reviews* (Third Edition).
41 Imison, C. (2011), *Reconfiguring Hospital Services*, The King's Fund.

7

How the new NHS architecture needs to change in order to assist the development of successful takeovers of NHS hospitals

We introduced this pamphlet by arguing that there are a large number of NHS hospitals that are failing and that there is no clear vision for moving the services that these hospitals provide to those that are more successful. Considering the complex process of making a takeover successful it is worthwhile only because there is a real and pressing need for policies that can radically improve those hospitals that are failing. We do not believe that it is politically possible to simply close failing hospitals, but we do believe that to improve their outcomes there needs to be a much tougher approach to change. A properly organised takeover will provide both the impetus and the capacity for the necessary radical change.

At the moment there is a merry-go-round of NHS managers that are moved from hospital to hospital in the hope that in some way the introduction of a clever new individual will transform the organisation from failure to success. There is little evidence that this change at the top is sufficient on its own to move an organisation from failure to success.

Whilst there are significant lessons to be learnt, and real opportunities that exist, from allowing successful trusts to takeover failing ones, none of this will happen unless the Government creates the conditions which encourage the hard work of takeovers to take place.

As we outlined in our chapter on the new architecture, the Government sets the entire framework for policy within the NHS. They can create a climate where takeovers have a greater chance of working and they can create one where takeovers have no chance of working. We propose a four-point plan for Government to create the conditions for successful takeovers:

i. Admit that there are a significant number of failing hospitals

The process of takeover that we are advocating in this pamphlet will only work if the institution taking over a failing hospital is encouraged to make the changes necessary in that hospital to radically improve it. The hospital is failing for a series of reasons that have not in the past been fully addressed and the institution that takes them over has to address that problem squarely. The rapid improvement process will mean changes in organisation and staffing as well as in finance and clinical practice.

For a failing hospital to be taken over and to improve radically there will be no substitute for the pain of change. If the existing leadership of the hospital believes that it can appeal to local political campaigns to stop that change they will.

This may be the hardest part of the Government's task of setting this clear policy framework. Even though in July 2012 there was the first recognition of a failure in the South London Healthcare Trust, no Government has had the political nerve to be honest with the public about the variation of outcomes that exists between the best NHS hospital and the worst.

For this to change the Government needs to cut through an unfortunate political logic. Governments after a few years recognise that there is something that needs tackling in terms of very wide hospital variation. They begin the process of recognising the necessary degree of change in failing hospitals. They put some of the worst hospitals under pressure. These hospitals locally start a political campaign to "save the hospital" and engage especially with opposition politicians. Across the country opposition politicians lead campaigns to save some of these failing hospitals. The opposition front bench bring these local campaigns into a national campaign to "Save the NHS". This campaign forms a part of the general election campaign. If the opposition wins the election this presents the new government with a short term political gain and a long term problem.

A wise government coming into power would use the same rhetorical tricks that they do in all other areas of policy. "The last lot messed it up. They have left us with a large number of hospitals that need very radical change to thrive. Because of the failings of nerve of the previous Government these hospitals are failing local people and we will not stand for it. We are asking the best hospitals to come in and radically shake up these hospitals. As a new Government we will not stand for the failures that have been left behind by our predecessors."

However unlike in every other aspect of policy, the reverse happens. One of the ways in which the opposition have won the election is to pledge to the country that they will save the worst NHS hospitals. This means that the first thing a new government does is not an analysis of the worst hospitals and what they are going to do about them. Instead, they announce within days of obtaining office a series of reprieves of failing hospitals.

Two Governments strongly committed to radical change in public services, the New Labour Government of 1997 and the Coalition Government of 2010, have both come to power partly on the backs of campaigns to save a number of hospitals that they should have spent their time criticising for not providing much better services. This political configuration of supporting failing hospitals as part of a winning general election campaign has meant that the very opportunity of a new government criticising the past is lost.

To improve the NHS, this vortex of failure needs to change. Governments need to be honest about the variations within the NHS and use their leadership to commit to radical improvement.

Government needs to claim the political kudos of improving outcomes for patients, not the rather odd political kudos that seems to come from maintaining institutions that fail their patients. In looking at successful takeovers we have learnt that for the process to work there needs to be clarity about who is playing what role in the process. At the moment there is a complete lack of clarity within the process of merger and acquisition within the NHS about who owns the assets that are being merged or acquired.

In the example that we use of Basingstoke and Winchester there was some clarity about who was doing what. The failing hospital is a non-Foundation Trust. As such, it is owned by the Secretary of State, and for the next few months until April 2013 it is the Strategic Health Authority who acts for the owner in any merger. The Trust Board does not own the Trust. The Trust Board has not gained the autonomy that it would have over its own affairs if it had become a Foundation Trust. Adding to the legal issues, the Trust Board has been complicit in the fact that it is a failing hospital.

In these circumstances, the hospital being taken over cannot be given the impression that it has the right to control its own affairs. It is not an equal partner in this process.

The organisation doing the taking over is a Foundation Trust. The Board of the Foundation Trust acts as the owner and has the duty to act in the best interest of the Foundation Trust. However, it is not completely autonomous because it has to prove to the regulator Monitor that the consequences of the takeover will not threaten the viability of the Foundation Trust. Competition in the NHS is regulated by the Co-operation and Competition Panel. The Panel has to agree that the final deal does not too radically diminish the choices available to patients in the area. This means that:

- the Secretary of State as the owner of the hospital to be taken over must actively support the process of takeover of his asset;
- the FT must be able to make out a clear case that this takeover is in the interests of the existing FT;
- Monitor will need to agree that the takeover does not diminish the viability of the original FT and;
- The Co-operation and Competition Panel must agree that this does not too gravely diminish the choices that patients have.

The Government needs to clarify all of these roles and make clear that it expects those involved to work in a streamlined way, and with pace.

ii. Stop the policy of merging failing hospitals with other failing hospitals

Despite clear evidence that the current approaches to hospital mergers will not work in 2012 the main approach that the NHS is taking to deal with failing hospitals is the development of mergers between them.[42] As the Government cannot get a good organisation to take over a bad one and improve it, they get two or more hospitals with problems to merge. Common sense might tell us that simply linking one hospital with clinical and financial problems with another will not suddenly create a single, successful hospital; it tells us those mergers between failing hospitals lead to a much larger failing hospital.

In the past, the Government has expected the Strategic Health Authorities to do something about failing hospitals. Within the new NHS reform architecture, the Coalition Government has given that task to the NHS Trust Development Authority. The problem for all of these organisations is that they have little feel for

42 *Health Service Journal* (2012), "Acute sector faces wave of mergers and reconfigurations", 29 March.

the market and no direct power over the best hospitals, which are Foundation Trusts. This means that the only hospitals that these intermediate planning tiers can tell what to do are the ones that they control, and these are the trusts which have problems. This means that by definition they are only working with problem institutions.

Supporting mergers between unsuccessful NHS hospitals because you cannot find anything else to do with them is not going to suddenly make mergers a successful method of improving failing hospitals.

iii. Incentivise organisations to take over failing NHS hospitals

The new NHS Trust Development Authority will only succeed if it develops good relationships with the two sets of organisations that have the skill and capacity to take over failing NHS hospitals. That is the private sector and the NHS Foundation Trusts. Any Government policy that wants failing hospitals to be successfully taken over depends on those organisations that have the capacity to carry out acquisitions. In the case of NHS hospitals there are only two groups that are capable of this. Those NHS hospitals that have been successful have become NHS Foundation Trusts and as such are outside the control of the Government or the NHS Trust Development Authority. The other group of organisations that could assist in the takeover of NHS hospitals is the private sector, both in England and abroad.

This means that compared to most previous mergers within the NHS, any takeover that involves a Foundation Trust cannot be a forced one where all of the organisations are told what to do. The Foundation Trust has to want to do the taking over. If the Foundation Trust does not want to take over the failing hospital it does not have to. In so far as Government policy can impact upon the way in which these Foundation Trust boards make decisions about wanting to take over a failing hospital, they can only do so by providing incentives to Foundation Trust Boards to do so.

What incentives might work? First, these failing NHS hospitals are costing HM Treasury a lot of money. South London Healthcare Trust costs the NHS in London £1 million a week in subsidy and has done so for several years now.[43] The trust is now in administration and may well be looking to a Foundation Trust to take it over. Over the last three years, the NHS has subsidised this failing trust to an amount of about £150 million. If three years ago a sum of money of this order had been offered to a takeover partner then it is probable that a takeover organisation would have materialised. This may seem a great deal of money to takeover a hospital, but in fact this money has been spent by the NHS over three years to subsidise failure. Why not use it to subsidise success?

Over the next few years if the money that would have been used to subsidise failing hospitals were used to encourage others to take over failing hospitals, then it may be possible to develop a market to make this happen.

Previously, the legislation surrounding mergers and acquisitions in the NHS acted as a strong disincentive for Foundation Trusts to take over failing hospitals. To merge or acquire another organisation a Foundation Trust was required to dissolve itself and be recreated as a new legal entity, a complex and cumbersome process. The 2012 Health and Social Care Act has reformed the M&A regime to make it easier for Foundation Trusts to acquire failing hospitals instead of simply merging.[44] The Act has introduced a specific provision that now enables Foundation Trusts to acquire new organisations and maintain their legal identity. By contrast, to merge with another organisation Foundation Trusts will still have to dissolve themselves. From a regulatory perspective, mergers are therefore more difficult than acquisitions. Government and Monitor should communicate the new provisions to encourage the NHS's strongest Foundation Trusts to takeover failing hospitals.

The other set of organisations that might be incentivised to takeover hospitals are the private sector. The Coalition Government came to power arguing that the NHS needed much greater private sector involvement in the provision of services to NHS patients. The long political battles that led to the passage of their Health and Social Care Act saw them move away from this position to one that seems anxious about making this case for change.[45] Indeed the Act was amended by the Government to stop the NHS National Commissioning Board from arguing to increase the proportion of NHS services that are provided by either private or third sector organisations.

43 Department of Health (2012), "South London Healthcare NHS Trust to be put into the Regime for Unsustainable Provider", 12 July.
44 Health and Social Care Act 2012 S169.
45 Bassett, D., Cawston, T., Haldenby, A., Majumdar, T., Nolan, P., Seddon, N., Tanner, W. and Trewhitt, K. (2012), *2012 Reform scorecard, Reform.*

The outsourcing of the management of the failing NHS hospital at Hinchingbrooke Hospital by Circle in 2012 is an example of what the private sector could achieve if it were allowed to play a role in this process.

iv. Make it easier for the organisation that takes over a failing hospital to make the improvements in the previously failing hospital

One of the main disincentives to the successful takeover of hospitals is how difficult this and all previous Governments' policies have made it to radically change hospital services. The local public together with local politicians have been provided with the opportunity, if they can persuade the Secretary of State to agree with them, to block all major changes to their hospital. Local anti-change campaigners can succeed in a political campaign to stop change.

We make the point in chapter 4 that a wise Foundation Trust taking over a failing NHS hospital spends some time and effort working with the public to demonstrate how the takeover will deliver better and safer services. But the Government can help local campaigns for takeovers by changing the way in which they talk about the need for change at a national level. At the moment, despite the current Secretary of State claiming that he wants to take politics out of the local NHS, he spent the first few weeks of his time in office going round the country opening up parts of hospitals that clinicians had agreed should be closed. Through actions such as this he is encouraging all local campaigns to complain against closures, in the belief that the Secretary of State will stop the changes.

Sooner or later, the Government is going to have to acknowledge both the clinical and economic case for radical change amongst NHS hospitals. The sooner it does so, the easier it will be for local change to be pursued with a prospect of success.

Bibliography

Academy of Medical Royal Colleges and NHS Institute for Innovation and Improvement (2010), *Medical Leadership Competency Framework*.

Appleby, J., Ham, C., Imison, C., Harrison, T., Boyle, S., Ashton, B. and Thompson, J. (2011), *Improving Health and Health Care in London – Who will take the lead?*, The King's Fund.

Bassett, D., Cawston, T., Haldenby, A., Majumdar, T., Nolan, P., Seddon, N., Tanner, W. and Trewhitt, K. (2012), *2012 Reform scorecard, Reform*.

BBC News (2007), "Landmark hospital merger approved", 30 March.

British Medical Association (2007), *Hospital reconfiguration: Good practice guide*.

Christensen, C., Alton, R., Rising, C. and Waldeck, A. (2011), "The New M&A Playbook", *Harvard Business Review*.

Corrigan, P. and Mitchell, C. (2011), *The hospital is dead, long live the hospital*, *Reform*.

Darzi A. (2008), *High Quality Care for All: NHS next stage review final report*, Department of Health.

Department of Health (2012), "South London Healthcare NHS Trust to be put into the Regime for Unsustainable Provider", 12 July.

Dr Foster (2011), *Inside your hospital*.

European Services Strategy Unit for the Patient and Public Involvement Forum East Birmingham (2006), *Good Hope Hospital and the Heath Care Market*.

Financial Times (2007), "Trust takeover of failed hospital shows way forward", 2 April.

Foster, G., vin Bismark, M. and de los Heros, B. (2010), *Global Entrepreneurship and the Successful Growth Strategies of Early-Stage Companies, Executive Cases: WPP*, World Economic Forum.

Fulop, N., Protopsaltis, G., Hutchings, A., King, A., Allen, P., Normand, C. and Walters, R. (2002), "The process and impact of NHS trust mergers: a multi-centre organisational study and management cost analysis", *British Medical Journal*, 325:246.

Gaynor, M., Laudicella, M. and Propper, C. (2012), *Can governments do it better? Merger mania and hospital outcomes in the English NHS*, Centre for Market and Public Organisation, Bristol Institute of Public Affairs, University of Bristol.

Ghobadian, A. and O'Regan, N. (2011), "Building from scratch a marketing services giant by acquisition: Case study and interview with Sir Martin Sorrell, Chief Executive of WPP", *Journal of Strategy and Management*, Volume 4 Issue 3.

Harding, D., Rovit, S. and Corbett, A. (2005), *Three Steps to Avoiding Merger Meltdown*, Harvard Management Update.

Health Service Journal (2012), "Heart of England pulls out of mooted George Eliot takeover", 21 February.

Health Service Journal (2012), "Acute sector faces wave of mergers and reconfigurations", 29 March.

Hinterhuber, A. (2002), "Making M&A work", *Business Strategy Review*, Volume 13 Issue 3.

Imison, C. (2011), *Reconfiguring Hospital Services*, The King's Fund.

Independent Reconfiguration Panel (2010), *Learning from Reviews* (Third Edition).

Kerr, D. (2012), "Business Meets Politics", Wellcome Collection, 31 January.

KPMG (1999), *Unlocking shareholder value: the keys to success*.

Matrix Evidence (2010), *The Employee Ownership Effect: A Review of the Evidence*.

Monitor (2012), monitor-nhsft.gov.uk.

Monitor (2012), *Compliance Framework 2012/13*.

News Shopper (2012), "Report says hospital mergers bring few benefits as NHS trusts in Dartford and Medway plan merge", 16 January.

NHS Midlands and East (2012), "Hinchingbrooke hospital and Circle start their historic partnership", 1 February.

Pike, C. (2012), *Inside the black box: How competition between hospitals improves quality and integration of services*, Co-operation and Competition Panel Working Paper.

Sirower, M. (1997), *The Synergy Trap: how companies lose the acquisition game*.

Spurgeon, P., Clark, J. and Ham, C. (2011), *Medical Leadership: from the Dark Side to Centre Stage*.

The Guardian (2012), "NHS hospital mergers fail to produce gains", 12 January.

The Independent (2012), "NHS mergers solve nothing", 12 January.

The King's Fund (2011), *The future of leadership and management in the NHS*.

Timmins, N. (2012), *Never Again*, The King's Fund.

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