NHS DEVELOPS AN AC

Mergers and acquisitions are firmly on the agenda for the future but have had a patchy record in the health service. The *HSJ* gathered an expert roundtable to wrestle over what makes M&A marvellous – and appalling. By Andy Cowper

The discussion began with roundtable chair and *HSJ* editor Alastair McLellan asking what made a good case for mergers and acquisitions in the NHS.

HR consultant Julia Whitehouse suggested that most mergers were for financial reasons, rather than service driven. She raised the common risk of rushing mergers, with insufficient care and attention to what made an effective, successful merger. Good reasons were about financial balance and recovery, hopefully to improve quality with service change to benefit patients.

Sir Robert Naylor, chief executive of UCLH, said: "I don't think there's any such thing as mergers in healthcare: it's virtually all acquisitions. Few organisations merge for fun; normally one (and sometimes both) are in clinical or financial distress." He emphasised that trusts' economic situation will drive mergers. Trusts with failing clinical standards came under huge pressure to merge.

He added: "There's clearly far too many provider trusts in urban areas: London has 42 but I don't think there's a case for more than about 12. There are too many 'small and struggling' on the periphery of London. The big problem since 2003 is that FTs need a failure regime. Far too many were being subsidised for failure: bailed out by the centre.

"Politicians must face up to the need to change the shape and structure of providers. So far, they haven't, which has led to many decisions I don't understand about clearly failing trusts." Sir Robert said that "the two drivers of acquisitions are economic situation and financial viability of one or more organisation and inability to maintain clinical standards".

Ben James, a partner at Hunter Healthcare, reflected that, in an NHS emphasising choice, patients' experience of providers may in time prove important to M&A-type reconfiguration, demographically and geographically.

Catherine Davies described her organisation Monitor as "agnostic" over what defines a good merger or acquisition: "There's no fixed view. We'll look at the impact on patient choice and competition, and analyse that. I agree with Robert that all such deals tend to be acquisitions in the end."

Ms Davies defined a key driver as improving service to patients: "It often starts with two trusts entering a service-level agreement together, who then find (or are told) clinicians are very loyal to their own trust, so they need structural change to get a common culture and certain benefits.

"It can also lead to better or more stable management (of which there's a high turnover), and having a different management team come in to a combined trust can bring financial benefits and facilitate rollout of best practice. Another case for change would be to get the ability to achieve FT status more easily by improving clinical and financial standards."

Economies of scale

She added that economies of scale and scope (flexible staff rotas and a wider pool of staff who can be on call) may be had if trusts were geographically close. Mergers also allowed more flexibility in service reorganisation.

Lucy Moore, an associate at Deloitte Consulting, who was integration director during the merger of Barts, Newham and Whipps Cross trusts, said: "Having been through the sharp end recently with Barts, every case has its own merits. Barts had a financial imperative, and a much greater productivity opportunity in one large teaching trust than in the two small acutes, giving the board confidence that financial performance and clinical quality will both improve over the next five years."

Ms Moore also suggested that a single much larger organisation offers a platform for strategic change, with staff together under one roof. "The risks of the merger not happening meant a potential threat of losing some tertiary flows that Barts relied on for size and scale. And the trust needed a mechanism for accessing capital over a longer period of time, which being part of a larger merged organisation facilitated."

Professor Naomi Fulop of UCL sought clarity on the question to which merger or acquisition should be the answer. She suggested the NHS often fails to identify this, and rushes to merger (or usually takeover). Various objectives seemed likely: to reduce costs; to improve quality; to centralise services, due to shortage of medical staff; to reduce management costs; and to get economies of scale and scope.

Once this was clear, "if a merger's the best way forwards, fine. But there's too often a cart-before-horse approach". Reflecting on her published

ROUNDTABLE PARTICIPANTS

Dr Mark Goldman management consultant and former chief executive of Heart of Birmingham Foundation Trust
Lucy Moore associate, Deloitte Consulting (restructuring expert)
Sir Robert Naylor chief executive, University College London Hospitals Foundation Trust
Bob Ricketts director, provider transition, DH, and commissioning support strategy and market development director, NHS Commissioning Board
Catherine Davies executive director of co-operation and competition, Monitor
Professor Naomi Fulop University College London, author of major study on NHS mergers
Matt Tee managing director, Reputate communications, former director of government communications, Cabinet Office
Julia Whitehouse HR consultant and former interim director of HR, Barts Health Trust
Gavin Johnstone managing partner and founder, Hunter Healthcare, which provides executive talent to the healthcare sector
Ben James founding partner, Hunter Healthcare
Alastair McLellan *HSJ* editor (roundtable chair)

QUIRED TASTE

The panel (clockwise, from top left): Robert Naylor, Lucy Moore, Bob Ricketts, Gavin Johnstone, Matt Tee, Alastair McLellan (right) and Ben James, Catherine Davies (bottom right), Julia Whitehouse (bottom centre), Naomi Fulop and Mark Goldman

study of mergers, "in the original round of our analysis, people didn't look round and consider alternatives". Professor Fulop added that trusts "can have a merger and yet little reconfiguration for years and years: if it's about reconfiguration, do we need a merger? Maybe, maybe not".

Management consultant Mark Goldman's question was simple: "Is this going to be good for business? If so, does the goodness available outweigh the potential badness of going through a hard process?... If you've done your homework well, there's a probability of success but, from experience, the new organisation may be hard to manage and there may be a performance dip in the immediate aftermath."

Bob Ricketts of the NHS Commissioning Board pointed out that the "declared reason for a merger exists in an often ghastly business case. This is often financial and above clinical matters in reality. It can also be around infrastructure, back office savings – [which are] minor – and taking out spare capacity". He added: "It can also be about sorting out a current clinical 'hotspot' but may not relate to the underpinning quality issues. And it's often been about sorting out poor management. M&A can be a good short term fix, without addressing the underlying problem."

'I don't think there's any such thing as mergers in healthcare: it's virtually all acquisitions'

Mr Ricketts described a "big conflation between merger activity and reconfiguration, with the stated aim to create a scale that can deliver clinical quality". He said: "Mergers are often a political issue. We've got too many institutions, which we need to deconstruct and work out the right pattern for services. Politically, mergers can often just be easier and buy you bit of time, but surprise, surprise: nothing actually happens in improving clinical quality, as opposed to acquisitions, which I think often deliver more.

"There's a clear difference as, if done properly with due diligence and planning, most acquisitions can be very successful, delivering increased market share – but it only works if the acquisition fits the business model. Some of the Transforming Community Services acquisitions did that, but some happened with no thought at all. Also what are the economic and clinical outcomes you want?"

Asked if mergers were in reality always acquisitions, Mr

WILDE FRY

Takeover targets: the panel heard that the NHS needed a 'clear failure regime' so weak providers could be identified as potential acquisitions for successful ones

Ricketts said that, from his experience in health authorities, mergers "were really difficult: you end up with each senior team 'dancing around their own handbags', as it were. Acquisition's much easier if you get the reasons right (and commercially, it's usually been more successful)".

He added: "Mergers in health have a very poor track record – perhaps the challenge should be 'is this an acquisition or a break-up?' There's a poor evidence base, and mergers seem to be unhelpful."

Matt Tee, managing director of Reputate, agreed that lots of NHS mergers had been unclear about the question they were trying to answer. He said people often went too fast to merger rather than considering other solutions. "Money's clearly a significant driver in any merger, but I've not seen one come close to justifying it[self] without promising patient benefit, and you can't do one without other in the NHS," he said.

"There may be a case for a merger to realise an opportunity. At King's Health Partners, we're looking to realise an opportunity to work on the international stage."

Gavin Johnstone, managing partner and founder of Hunter Healthcare, noted that in the commercial world, M&A was often about getting to the next step of commercial advantage but the NHS showed little sign

'We were very clear that St Thomas' was taking over Guy's – Guy's had lost'

of such proactive thinking, and responded reactively to political and economic challenge, rather than taking the opportunity to discuss future sustainability.

Sir Robert observed: "I've been involved in acquisitions, all of which were financially driven. In the NHS, I can't think of any M&As that have really happened because of quality considerations. If we look at where Monitor steps in, provider failure is almost always driven by underlying financial problems. And when a trust gets into financial difficulty, they compromise quality. The next five years will be all about how the NHS maintains quality under the economic challenge – and the economy will get worse.

"I've only been part of successful acquisitions: none failed or needed to be undone. Keith Palmer's analysis for the King's Fund of the south London health economy shows how when you to try to merge several failing providers, you get one much larger failing provider.

"There has to be a fit with your culture to make an acquisition worthwhile. UCLH's culture is all about clinical leadership and responsibility: we define ourselves by that, and it defines the staff we hire as well. We should look at the capability of successful organisations, however defined, and how to align them with failing organisations – and encourage the latter to be acquired by the former. However, if I were failing, the last thing I would want was a recognition of my failure.

"We really haven't created a strong enough failure regime. In London, a large number of trusts are clearly failing, yet continue to be subsidised by the centre for reasons we may want to explore, which are political.

"With a clear failure regime, as in the private sector, shareholders step in and the firm must sell itself off or be acquired. Until we have a clear failure regime, I don't think we'll get to situations where more successful organisations take over and apply their successful techniques to failing ones."

Mr McLellan asked Sir Robert if he meant there were too many mergers and not enough acquisitions? Sir Robert described a "tendency for failing organisations to huddle together and try to create something that may be successful". "In London, we've seen mergers of failing organisations – financially or on quality; in the commercial sector, we wouldn't have two bankrupt organisations merge," he pointed out.

Acquisition or merger?

Mr Tee emphasised the importance of culture and language: "Use of the word 'acquisition' is pretty new; they're almost always called 'mergers', which can impart a cultural problem. We were very clear that St Thomas' was taking over Guy's – Guy's had 'lost'. Doing that avoids any pussyfooting pretence of mergers of equals."

Ms Davies noted that Monitor's research "shows that some, but not all, provider organisations are constrained by other organisations around them, and react to competition in their area". She added: "There are various ways of improving care quality in hospitals: competition is one tool to incentivise delivery of good quality care. We try to assess a








merger's impact on patient care and competition, and look at acquiring organisations' commercial documents. Our view is that, if there's a risk to competition, a chance to incentivise quality can be lost, and without that tension and pressure a potential reduction in care quality can follow, especially with elective quality.

"In the case of Barts, we looked at Newham patients and GP referral patterns, and Newham patients were choosing Whipps Cross and Barts. So options for choice would be reduced as a result of transactions. So Monitor said: 'We hope this works, but if not, you need a Plan B if quality does deteriorate – commissioners must step in to allow swift action and if they can't meet the need at Newham, then you should let others come in.' And we made a similar decision to that with Dartford and Gravesham.

"We work with the system to have quality indicators written into contracts over mergers. If they fall below these, commissioners must step in fast and act."

If commissioners didn't act once quality fell, Mr McLellan asked, then what followed: a sanction, penalty or incentive? Ms Davies replied: "Monitor will keep our eye on what's happening, working with the NHSCB saying 'we expect this – why is it not happening?' The current regime is not statutory but policy, so we have no legal powers to compel. We try to bring more transparency to these transactions, measuring what happens. Local people should say 'are services deteriorating?' and so bring pressure in that way."

Was Monitor content that was a robust enough approach – trusting commissioners, rather than having levers to do it if they didn't? Ms Davies said that the "safeguards are relatively new, so we have to see how they work. If they don't, it's back to structural remedy".

It sounds, said Mr McLellan, "as if CCGs' behaviour will guide you". But would Monitor have to be more hardline?

Ms Davies replied: "Potentially, we might have to do that. Another important point is whether FT mergers fall within the OFT scope [the roundtable predated the Bournemouth decision]. There's some debate over whether the social regime applies for FT mergers. Parliament decided that 'no, it's the same rules as other sectors', so if the OFT thinks that's an issue, they can refer on to the Competition Commission, who can drive legal remedies."

Too poor to merge?

Would Monitor ever say these are two failing organisations that should not merge? That, Ms Davies said, "sits uneasily within the framework: we assess competition and co-operation, not just for their own sake but as proxies for measuring quality of patient care. If a good organisation acquires a poor organisation, there are risks to the good organisation's level of quality".

Mr Ricketts added: "The terms of reference of the Co-operation and Competition Panel are tight – choice and competition. The CCP depend on other players in the system: they can actively comment, but it's not their decision."

Ms Moore added: "Two failing organisations are unlikely to succeed together, but it's fundamental to understand why they're failing. It would be very challenging to run a successful DGH relying heavily on maternity and A&E in this climate.

"The business model some trusts operate is not viable. It's not clear whether we collectively are creative enough to have worked out what business model could make those trusts viable. Let's really understand why trusts are failing, to help us work out whether merger's the right thing to do.

"Why do mergers fail? At Barnet and Chase Farm, I arrived six months into the merger and was struck by the absence of a plan; how both finance systems didn't talk to the other, nor did the patient flow systems. In the private sector, mergers are meticulously planned, including merging systems, and 1 per cent of annual turnover is usually put aside to fund this."

Professor Fulop added: "The evidence is clear that mergers can be seriously disruptive; delay service development; take

WILDE FRY

Listen to the doctors: the panel debated the obstacles presented by the public to reconfiguration and it was suggested that clinicians might persuade them – if they made a case for change on safety and quality grounds

senior management eyes off the ball for two years; and have significant emotional and cultural cost to staff. Many don't achieve their publicly stated aims. Many take a long time to reconfigure services. The common view is that Guy's and Tommy's took 10 years to deliver results."

Professor Fulop's research looked at nine mergers in London between 1999 and 2002. In that timeframe none had really worked, though positive things were found – opportunities for learning and sharing good practice increased. "They hadn't thought through what they were trying to achieve and what the best method was, which may not be merger; and they didn't put in the effort pre-merger," she explained. "The timeframe to deliver benefits was too often felt to be a couple of years, which may be far too low."

Mr Goldman stressed: "A merger will not cover up a system failure. If you respond to a system failure by trying to bring the failing acute elements together, it will not work."

Bob Ricketts added: "Failure of mergers seems linked to unclear rationales or picking the wrong partner. Financially, patient and taxpayer interests are often very far from the main considerations: mergers tend to be tactical in nature, not asking 'how do we deal with underlying system failure?' Outside London,

'If you say we know our local care is unsafe, the public say make that care safe. It's a challenge'

what do we do with small clusters of provincial hospitals?

"It's about the right provision model. The NHS culture has always understated the opportunity cost, and though we may want to drive service reconfiguration to deliver improvement, management teams can get so exhausted by the merger that improvements peter out. Sometimes they fail as people haven't examined wider options: for provincial hospitals, clinical franchising may get much faster clinical improvements, like Moorfields in Buckinghamshire and Bedfordshire, making care much better and safer.

"Mergers also fail because commissioners are weak players, who don't know what strategic issues they need to understand. It's often about who survives among leadership players. Transforming Community Services is a good example: I won't name failures, and we're only a couple of years in – but it's the profoundly different culture that some acquiring mental health trusts didn't try to understand.

"Where there's really good clinical leadership and management, mergers have made a difference, but in the absence of good clinical leadership, there's no benefit."

Mr Tee added: "We rarely ask why rational people did what seems irrational in creating unlikely mergers that failed, and the one word answer to that is politics. You find dislocation between the eventually stated aim and the original rationale for merger and what the benefit for players in the system was, which led to heroic assumptions in business cases and optimisation bias about business plans that led to failure.

"It's interesting that no one mentioned South London Healthcare Trust's failure. You can look at it as rational: why would merging three failing acutes under a first-job CE be the conditions for success?"

What gave the group confidence that CCGs would be stronger commissioners?

Mr Ricketts said: "If the NHSCB are relentless in holding CCGs to account for outcomes, CCGs will be only contracting with the best providers. I'm confident there will be much more clinical focus. We're also seeing CCGs going direct to secondary care clinicians: they seem to be getting into those conversations quickly. One CCG's setting aside their structural review, and saying to their acute 'here are our priorities'. Good for them!"

Businesslike approach

Sir Robert emphasised the need to run trusts in a businesslike way: "My current chair is deputy chair of NM Rothschild, who do huge M&As internationally. And he observes to me that UCLH now runs just like any commercial organisation. We've looked at potential acquisitions and walked away. Why... risk our future success to sort out via takeover a clearly failing trust?

"There are successful examples: we acquired the Royal Nose Throat and Ear on 1 April 2012, having noted their culture of clinical engagement. We did the deal to knock their building down and re-provide their service on the main UCLH site, and nobody noticed." (Mr McLellan and Ms Davies noted: "We did.")

Mr Tee said: "One reason Robert can point to successful

acquisitions is that, because of his stature and career, he takes people with him. If he meets political barriers, he can withstand and overcome them, and knows the way to push back on unrealisable requests."

Sir Robert suggested that success in merger or acquisition rested on four issues: first, having a plan and a strategy; second, getting cultural integration between organisations; third, engaging staff, and expecting clinicians to champion; and, finally, having good communications.

He added: "We won't really get into this in a system-wide way unless we stop rewarding failure and have a much more robust failure regime especially for non-FTs."

Did South London Healthcare Trust show him that this was under way? Sir Robert replied that he was "encouraged to see that: it was one of the better things Andrew Lansley did". He added: "Many other trusts should look in the mirror and say 'this is where we're heading'. And the centre could do a lot more. Every £1m spent on subsidising failing trusts is £1m not spent improving health.

"My final point is about the available leadership talent. We have far too many trusts now: in its current form, the NHS needs about 1,000 CEs and chairs and 6,000 NEDs. We just don't have that pool of talent. One real tragedy of the current

reorganisation is that the service is losing a cadre of talent who are taking the easy option and taking the money and going. And we lack replacement talent of sufficient experience coming up through the system... and we lack enough talent to run the trusts we have now.

"So we really do need clearer failure regimes. As well as that, we need to bring trusts together to have mass. We need big organisations in London to shape the future of healthcare. CCGs won't do it: they're too small and SHAs are gone. There'll be bigger commissioning organisations in two to three years' time."

Benefits analysis

Ms Davies said: "The key to getting a merger or acquisition right from the point of view of Monitor and the CCP means you must articulate what you want to achieve – the benefit case vs any cost from reduced choice and competition. We've seen growing sophistication [in] the analysis we're sent."

Ms Moore added that getting mergers right "is all about bringing the people with you and planning in real depth". "Day one when you merge is the end of the beginning, not the end," she said. "You need to think more about the single culture Robert described, and how you'll try to measure it."

In planning for mergers or acquisitions, there are clear issues around trusts' confidence that they have or can access the correct workforce and skill mix to make the change work. The discussion emphasised the dedicated effort required to make this process succeed.

Trusts needed to assess the HR implications of their M&A plans, including assessing internal staff capability and capacity. If skills were in short supply, an obvious question would be whether to employ or hire them from people with proven expertise.

Gavin Johnstone said: "Whether it's mergers, acquisitions or small scale change, there's a market requirement to bridge the gap between receiving external consultancy theory and translating it into on-the-ground implementation.

"Trusts often select a trusted board member to lead a large scale programme... But there's a real opportunity here for trusts to engage with skilled change agents: individuals who are professionals in this practice and bring with them best practice, change methodology techniques – often with both private and public sector experience – and an understanding of what does and doesn't work on the 'shop floor' of a hospital."

Public resistance

Professor Fulop felt the group was correct on the importance of thorough planning, but warned that conversations with the public about quality and safety were likely to be fraught.

"I've done work on acute reconfigurations, and the public refuses to make trade-offs between quality, safety and travel time for general acute care, with some exceptions for maternity and emergency. If you say 'we know our local care is unsafe', they say 'make that care safe'. It's a challenge.

"The big driver of the reconfiguration work on London's stroke services, moving to fewer sites providing the service [which has saved lives] was driven by a significant group of clinicians saying 'we're unhappy with these services'. The public will probably listen to messages from clinicians, provided they're pretty united and make clear that the decision isn't solely financial, [but based] on the need to reconfigure provider services to improve quality and safety." ●

WILDE FRY