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cutting through complexity

HEALTHCARE

Do it, don't do it, or fake it?

Hospital Collaboration in the NHS

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contents

Introduction

The pace of change across our economy is accelerating: time horizons are ever shorter and business models are overturned with increasing regularity. Change within the National Health Service is no exception to that trend as the system attempts to meet the increasing needs and expectations of patients, advances in technology and new thinking around clinical practice.

A failure to keep pace would seriously compromise the NHS as the demands upon it grow.

One response from healthcare providers has been to collaborate more with other trusts, allowing them to combine assets and cut costs to make more resources available to patients.

The way healthcare providers go about this will determine their success. They can either embrace collaboration, continue to go it alone, or agree to collaborate but in name only – in other words: do it, don't it, or fake it.

Too often they take the latter route, and as a result neither patients nor staff enjoy the intended benefits of the merger, alliance, network or informal collaboration.

This publication, which builds on our recent report, Hospital Collaboration in the NHS, seeks to uncover the myths surrounding mergers within the NHS. It identifies why some mergers fail, debates whether change should be imposed from the top or led by from front-line staff and looks at what model of collaboration yields the best results.

I hope our opinions help shed some light on this issue.

Andrew Hine
Head of Healthcare, KPMG in the UK

76%

of hospitals surveyed in KPMG's 2015 report, Hospital Collaboration in the NHS cited they were looking to embark on some form of collaboration in the next three years.

Busting myths

The running of the NHS raises strong emotions in Britain. Failures in the healthcare system usually make the front pages and, as my colleagues argue, many of the mergers that took place in the late 80s and early 90s were unsuccessful. But as Carwyn Langdown writes, the idea that they're all failures is a myth.

By contrast, Matthew Custance argues that it is cost that is often, wrongly, blamed for failure. We should not be misled by the headlines around the costs of merger.

Matthew Custance

Matthew is a partner within KPMG's Health Corporate Finance business, specialising in major transactions. He is also the front man of a rock and roll band. As a child, he was interested in becoming a dentist like his father, but as he grew older he became interested in business. Today, Matthew specialises in commercial and financial advisory in the publicly funded healthcare sector. This has ranged from advice on the development of privately funded healthcare infrastructure to assisting NHS bodies to plan and complete commercial transactions. In addition, he advises private sector organisations wishing to do business with the NHS.

> " I would like the NHS to be more commercial and to embrace transactional change more fearlessly. It needs to be confident in negotiating its position with other players and hide behind procurement laws less. I would also abolish comparisons between the pay of Executives in the NHS and the Prime Minister's pay. We keep expecting people to run billion pound organisations for less than £160,000 a year. This limits the amount of talent that walks in the door. "

NHS merger costs are over-egged

The idea that mergers between NHS trusts are an extravagance is a myth. A healthcare merger is no more costly than a large, well-managed performance improvement or cultural change project, which is what it often is.

> **Unlike the private sector, the NHS faces political interference.**

Whenever we think of healthcare mergers there's an instant association with cost and enormous headline figures in the hundreds of millions of pounds. Unsurprisingly, that generates outrage from commentators, politicians and members of the public. It's entirely reasonable to ask why it should cost so much to bring two NHS organisations together.

Having said that, I believe that the headline figures can be extremely misleading. Ultimately, the transaction cost of the merger need not be eye-watering. The real cost is in solving the underlying problems that led to the need for the merger in the first place and the historic problems within the trusts. It is these things that make for big numbers; such as the cost of fixing deteriorating estate, reorganising

> **mergers within the NHS almost always come about as the result of failure**

staffing to clinically safe levels (including recruitment costs), planning out the merger, or implementing improvement plans, for instance. Even costs that look like "wasted transaction costs" are often aimed

at giving the organisation clear and reliable management information that enables them to plan a sustainable future.

When you bring two organisations together, you need to cross-fertilize the best of both. That requires people to understand what each organisation does and the costs and benefits of those approaches. You need to document and share processes. When you're talking about organisations with a turnover of anywhere from £70 to £750 million that's a lot of organisation and communication.

> **The due diligence process...often demonstrates that problems go much further and deeper than anticipated.**

All of this requires an investment of time, which in turn costs money. However, doing this well will save much more in the long run.

Unlike the private sector, the NHS faces political interference. There is much more scrutiny around failure than not achieving more success. This means mergers within the NHS almost always come about as the result of failure, often financial, leading to one trust acquiring another.

You can't simply put a high-performing and a failing trust together and expect it to work. That would financially undermine both and standards would likely drop. So acquirers need financial assistance from NHS England or the Department of Health to take on failing trusts and invest in solving the problems hence the "inflated" headline cost.

The due diligence process that takes place during the course of a merger involves going through both trusts' liabilities, on and off the books. This often demonstrates

that problems go much further and deeper than anticipated. For example, in the case of Mid Staffordshire, tens of millions were required to bring the site up to the minimum regulatory standard after decades of underinvestment.

Neglected estates are hardly confined to Mid-Staffs. In London, 25% of the hospital estate predates the establishment of the NHS, 34% of the GP estate requires rebuilding and a further 44% of it requires repair. In other mergers financial assistance is required to update technology, raise staffing levels or generally bring facilities up to date.

Going forward without addressing these liabilities is a false economy, as it leads to further financial pressure and ultimately failure within the trusts.

If two high performing trusts without these issues were to merge, the costs would be much lower because there would be no need to rectify the back log of failure. High performing organisations merge frequently in the private sector, but in the NHS (an organisation currently motivated more by need than opportunity) there's no burning desire to go through such a difficult process.

I think it's really important that we don't let cynicism about change blind us to the depth of the problem that can be solved through mergers. Talk of costs make for good headlines, but the costs are not all they seem.

> **I would like to see the NHS and its current emphasis on how its services configured and resourced move to a more preventative system and working better with social care, to maintain peoples' health and well-being.**

by Carwyn Langdown

We never hear about successful mergers

I wouldn't like to say that we're a nation of pessimists, but for me, the single biggest myth surrounding mergers in healthcare is that they are all failures. There is a tendency to dwell on the negative in the British media, which has, at least in part, led to this with headlines screaming about millions of taxpayers' pounds being wasted or outraged columnists calling for heads to roll. This overshadows the success stories and fails to add to the understanding of the difficulties that NHS mergers have to overcome.

> **Mergers are often seen as a panacea that will solve a problem; the end of a process rather than the beginning.**

There are some fantastic examples of successful hospital mergers, such as Guy's and St Thomas' NHS Foundation Trust, which is absolutely seen as a single entity in the minds of NHS staff and the general public alike. Equally the UCLH NHS Foundation Trust is actually the result of a succession of successful hospital mergers, but those don't get written about, because success doesn't make for much of a story.

While there have been failures in the past, I don't think these failures were because of the merger itself but rather a fault in the design of the process that the merging organisations went through.

Mergers in the NHS tend to be more challenging than in the private sector, because they're often enforced acquisitions due to a failure in some area, whether it be clinical or financial which has a series of ramifications.

Any problems which led to the merger, such as its operating model, buildings that have suffered from years of underinvestment or a lack of up to date equipment, will take a considerable investment of time and money to put right.

There's a lack of understanding around the terminology that is used in these cases. The term merger is largely used for both a merger and an acquisition within the NHS. I think this is because acquisition sounds more aggressive, and merger is used in a mistaken attempt to mitigate the sensation of being taken over.

The result of an acquisition being termed a 'merger' is that staff are left bewildered as to why they aren't involved in developing the strategy for the future of their new organisation. People on the ground often don't get the opportunity to actively contribute to the planning of service delivery, and they feel that new ways of working are simply imposed from the top. While merging may be the right strategic direction to follow, which arguably may be better managed using a top down approach, this in turn leads to a lack of real buy-in from staff.

> **Mergers within the NHS take years to work, they are never an overnight success**

Another problem is the lack of planning. Mergers are often seen as a panacea that will solve a problem; the end of a process rather than the beginning. The pressure on management to deliver immediate savings often leads to a lack of vision around what they ultimately want to create in terms of organisation and service delivery.
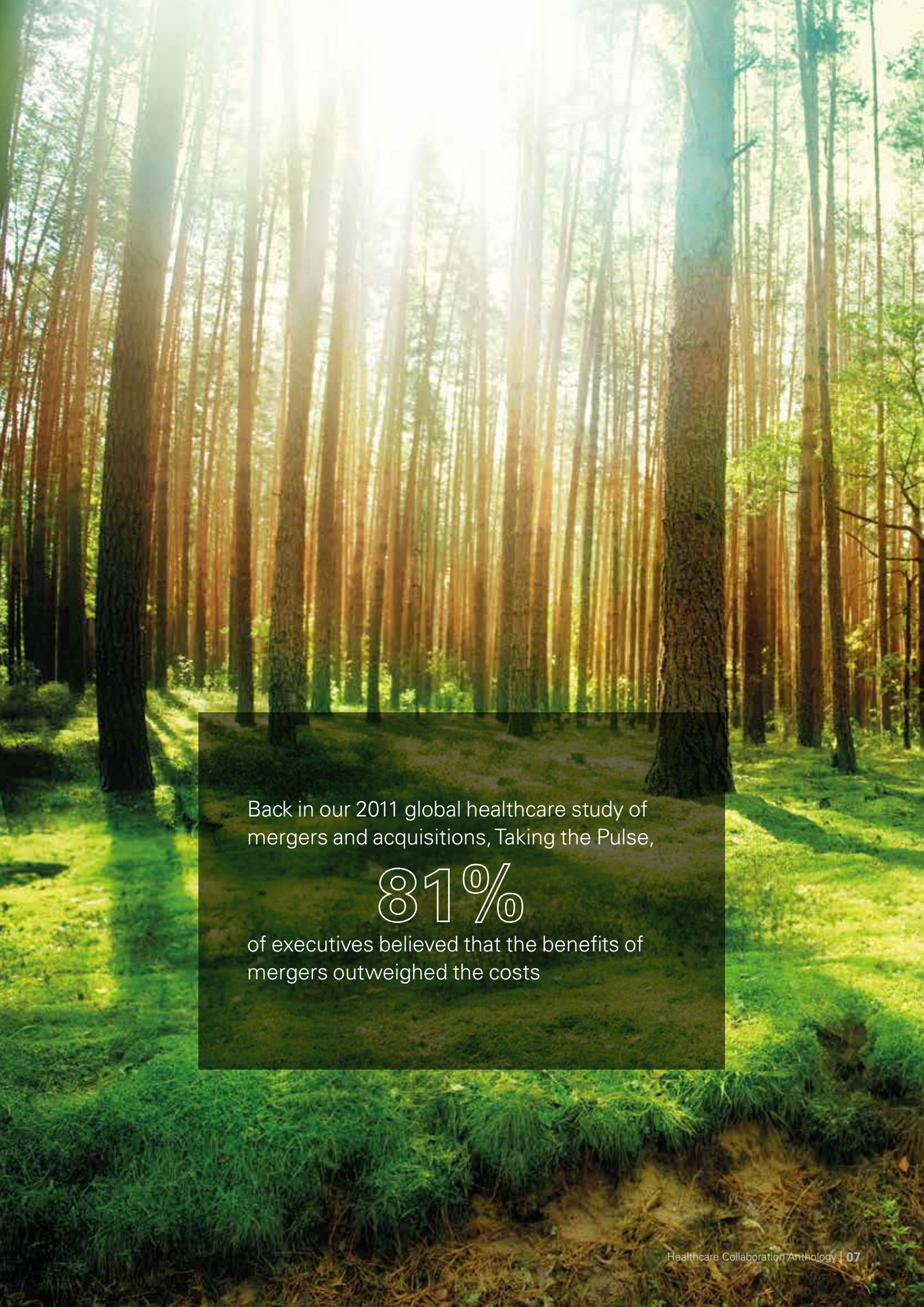
They work on step one but don't go beyond to step two and three in order to work out where they want to get to.

During the process a lot of staff will be focussed on whether their job is safe and where they'll be sitting. Although this is entirely understandable there also needs to be some understanding of the reason for merging, and what it is aiming to achieve. That will help with the organisational integration in whatever form that might take.

Developing and embedding cultural integration can take years to truly take root. I think that people vastly underestimate the timeframe involved. Mergers within the NHS take years to work, they are never an overnight success and what may at times look like failure may simply be part of the process.

There's so much going in in a merger or acquisition: there are a lot of different pieces of the puzzle that need to fit into place. Both of the parties taking part in the merger need to contribute to where the final destination is going to be and actively work together to create a new identity, whether they're the acquired or acquiring part of the organisation.

Success should be measured in terms of the quality of service that's being delivered, as well as long-term financial and operational sustainability. Whether the merged Trust is instantly profitable is far less important than whether it is a sustainable model going forward.

Back in our 2011 global healthcare study of mergers and acquisitions, Taking the Pulse,

81%

of executives believed that the benefits of mergers outweighed the costs

Learning from the past

Hospital mergers will ultimately fail if all they do is change management teams and put a new nameplate over the entrance. Too often managers have viewed collaboration as an end in itself, as my fellow contributors point out.

Beccy Fenton highlights the lack of pre-integration planning and how this leads to staff disengagement. Former health secretary Stephen Dorrell calls for more patient focus rather than relentless structural change. And Carwyn Langdown focuses on the lack of cultural integration during mergers.

Meanwhile, Matthew Custance lays the blame for failure in their complicated, drawn-out nature. He calls for a change in the regulations to allow for a simpler, more effective process.

Beccy Fenton

Beccy is a partner within KPMG's Health Public Sector Management Consultancy practice and holds over 15 years' experience in the acute sector of the NHS in Board roles. Earlier in Beccy's career, she set up the first and only NHS to NHS consultancy firm. As a child she actually wanted to become an astronaut but severe motion sickness soon quashed this dream. Instead, she studied Engineering at Oxford, then became an accountant. In her free time enjoys taking her children Poppy (12) and Freddie (5) skiing and sailing.

> If I were put in charge of the NHS for 24 hours, I would abolish some of its short-term targets and replace them with longer-term transformational goals. Namely, I'd bring patient experience and staff satisfaction to the top of the performance agenda.

A successful merger is a happy merger

NHS staff need to understand clearly defined reasons for going into the merger process if they are to be engaged and help drive forward the new organisation. They are, in general, highly committed to providing the best outcomes for patients. However, staff frequently don't see how their daily work fits into a bigger picture.

This disconnect is often exacerbated during a merger process, just when it's essential to get everyone onside. A lack of pre-integration planning means that often trusts do not think about what the real vision is for the new organisation. Putting two trusts together and expecting them to be more successful as a result is not an effective strategy.

Staff are unable to buy into short-term thinking and a focus on solving immediate financial issues. They need to be clear about the benefit to patients of any reorganisation.

There's often a lack of two-way communication between boards and frontline staff. Typically in a merger process, boards are focussed on financial and operational planning, with staff engagement trailing in a poor third.

> The attitude of 'We're all the NHS, we'll just bolt together' is naive.

The planning and effort put into staff integration is an add-on, when it happens at all. Staff are left unclear about both the reasons behind merging and their own individual roles in making it a success.

Many staff feel that their job is threatened and a lack of communication exacerbates this.

Acquiring trusts can create additional tension by going into the failing trust as though they are somehow superior. This attitude is frequently reinforced by all the stakeholders, including the regulators.

> The benefits of a merger will only be achieved...by full cultural integration of the merging organisations.

Staff from the failing trust who are shut out from the decision making process will immediately be disengaged. While the acquirers may well be in a stronger financial position, they're not necessarily better in every aspect. There is another way, involving more effective communication between the two trusts supported by a proper cultural integration plan.

The attitude of 'We're all the NHS, we'll just bolt together' is naive. Unless these differences are integrated, you get an 'us and them' mentality where staff continue to work in silos doing things the way they've always done.

There are massive cultural differences both within and between NHS organisations – everything from management styles, working practices and how staff interact with patients. The benefits of a merger will only be achieved by understanding these differences followed by full cultural integration of the merging organisations.

Even in cases where staff have been carried forward to the point of merger,

management attention soon shifts back to the daily business of managing the hospital post-merger. This is unsurprising given the demanding nature of managing hospitals, but it does mean that the planned benefits fail to materialise.

Keeping newly merged organisations on track in terms of delivering integration and change management is going to require an element of compulsion. There is a role for the regulator here in supporting organisations post-merger.

The Trust Development Authority and Monitor already undertake regular performance management checks. Adding the delivery of planned benefits to these checks would help ensure continued management attention to staff engagement, integration and, as a result, more successful mergers.

by Stephen Dorrell

Let service drive structure

It's an old truism that the majority of mergers and acquisitions fail to deliver the benefits claimed for them by their promoters. In this respect, as in so many others, the provision of health and care services is simply a sector of the economy in which the same rules apply as in all the others.

Mergers and acquisitions are often promoted on the basis that a different management structure will lead to more efficient service delivery. Too often the belief is confounded because it is based on the misconception that the key to successful change management is clear sighted top management.

> ❝ Insiders focus on the likely impact of proposed changes on themselves

The attitude of senior management is certainly important. Strong and consistent management can facilitate change, while the wrong culture can stifle initiative and disable would-be reformers.

But real and sustainable organisational change requires senior management to do much more than set out a vision and reorganise the organogram. It requires them to engage with people in the front line and support them as they adjust their working patterns to meet changing needs.

Senior managers must see the organisation from the bottom. Instead of focussing on structures and budgets, they must understand the experience of the people who use and deliver their services.

In a health and care organisation this understanding will have multiple different perspectives. It will need to take account of changes in specialist clinical knowledge, changes in patterns of disease, changes in medical and other technology, and – most importantly – the individually expressed preferences of the people to whom the services are delivered.

Organisations whose understanding of the answers to these questions is imperfect will not find it is improved by structural change.

Quite the contrary. Organisational upheaval always has the same result. Insiders focus on the likely impact of proposed changes on themselves and other insiders, with the result that they reinforce the outsider status of the people for whom the services are intended.

Far from promoting service change, organisational upheaval more often undermines it.

So is senior management caught in Morton's Fork? Damned if it does reorganize and damned if it doesn't?

> ❝ successful mergers create new institutions which draw strength from their combined legacy

Not necessarily. The mistake is to confuse cause and effect.

If working patterns change, or need to change, it is likely that organisational structures will also need to change to encourage different ways of working. Indeed the lessons from elsewhere in the economy demonstrate that structures do change as new demands are met by new technologies. It would be surprising if that was not true.

But the key principle is that form should follow function.

As working patterns change, new structures will develop which support new patterns of working – and good management teams will want to be early adopters of the new forms. Development of these new forms will sometimes require mergers and acquisitions of existing structures.

But the key point at every stage is that changes in ownership are driven by a changing vision of how services should be delivered to those who rely on them.

Which is why successful mergers create new institutions which draw strength from their combined legacy but explicitly create a new culture which is independent of the legacy.

Organisations only survive if they are useful. When they stop being useful they begin to decay, and it is powerfully in the interests of the people who rely on their services that the period of decay is cut short by the process of renewal which is the result of a successful merger.

by Matthew Custance

Warning: slow approval times may be deadly

I think we're currently seeing a lot of merger activity in the NHS because the alternatives have run out. Trusts in financial difficulty have nothing left to cut in terms of costs, which leaves either transforming the way care is delivered or mergers as the only options.

Time, as the result of the layers of bureaucratic complexity, is the enemy with both of these models. Indeed, this is something that has been recognised in The Dalton Review which calls for mergers to take place in less than 12 months. However, under the current system that is pretty much impossible.

Given this level of complexity it seems almost miraculous that any organisations manage to merge at all.

The best option is to transform the model of care delivery to deliver more efficient care at better value. This would mean more treatment of patients in the community, making better use of technology and making sure everyone sees the most suitable medical or care professional.

None of this is achievable within the current regulatory framework without public consultation, judicial review and ministerial approvals. This means that it's impossible to reconfigure services in less than five years and most of the time it takes 10, as has recently happened in Barnet, in North London.

This time lag means that proposals end up being implemented in a health service that has already moved on. In addition, passing through all the approval procedures waters down the changes proposed, so they're rarely as bold, wide-ranging or beneficial as they were originally designed to be.

So transformation is, at best, a long-term option, which leaves us with mergers which are themselves an arduous process.

Mergers ask a lot of people overseeing their implementation both in terms of the volume of work that they pile on to already stretched staff, but also in terms of the emotional journey.

People are required to give up or extend sovereignty of their organisation which in turn threatens people's jobs, allegiances, loyalties and ways of working. This is made even more complex by the layers of bureaucracy surrounding NHS mergers.

There are three layers of approval process that are required for an NHS merger.

Initially, a strategic outline case must be approved by both Trust boards, the local commissioners, NHS England and the regulators managing the Trusts, which will be one or both of the Trust Development Authority and the Monitor.

The next stage is an acquirer business case, which again requires the approval of all those authorities plus the Competition and Markets Authority, the Department of Health and potentially the Treasury. Then there is a full business case which needs to be approved by all those authorities all over again.

Given this level of complexity it seems almost miraculous that any organisations manage to merge at all. It's also hardly surprising that managers experience deal fatigue at the point of completion.

Just as they feel they've finished, they've got to begin again in terms of implementing the changes, inspiring their staff and delivering approaches to collaboration with an organisation they were previously competing with.

Frankly they're often simply exhausted, and as a result many of the expected plans and benefits fail to materialise.

"I'd like to see a maximum six month period for going out to public consultation on changes to care

I think the whole process needs to be dramatically simplified. The first and most important thing I'd like to see, is to change the process around consultation, to allow for some transformational changes to healthcare. If this were to happen we might not need to have so many mergers at all.

I'd like to see a maximum six month period for going out to public consultation on changes to care, with the final decision on that process being binding on everybody. I'd also have that final decision being made by a reconfiguration panel rather than a minister.

In terms of mergers, I would look for a single round of approval upfront to create an in-principle agreement to explore the transaction which could be informed by a relatively simple business case. From that point the process could be managed by a steering committee, which includes the stakeholders.

The steering committee would need a progress report each month to explain how they were tracking against the original plan. Then at the end of the process they would produce a full business case which would trigger the transaction.

Private sector mergers happen all the time in under a year, and I think that with a simplified process, the NHS would stand a chance of matching this and falling into line with the Dalton Review recommendations.

Carwyn Langdown

Carwyn joined KPMG in 2008 and has over 18 years' experience in both the NHS and private sector, covering clinical, financial and managerial positions. His main focus lies in care system redesign, looking at a whole system's approach to developing and improving health and social care. He is currently working on the implementation of Northern Ireland's Transforming Your Care programme. Carwyn has a Master's in Public health at the LSHTM, focusing on health systems and health economics. He also has a degree in music and used to give piano lessons to staff whilst working for the NHS.

The identity issue

While healthcare mergers within the NHS are a very challenging prospect for a number of reasons, I think that one of the largest contributing factors to their failure is individual organisations being unable to let go of their former culture and identity.

In many cases, the merger is actually an acquisition with a larger or more successful Trust taking over a smaller or a failing one. This instantly gives rise to the perception that the acquiring organisation feels that they are better in some way, and that the smaller or failing Trust's identity will be lost within the bigger one. So the relationship is broken before it has even begun.

Sadly, I think there's very little emphasis on the integration of organisational cultures when it comes to healthcare mergers. It's seen as a soft issue and not of real importance. It is typically much better managed in the private sector, which I believe is one of the reasons why those mergers are often more successful.

This communication about the identity of the newly merged organisation, and engaging staff in how working together will benefit patients is fundamental in order to move towards a fully integrated system. When the merger or acquisition is simply imposed from the top, staff don't have the means to understand why merger or acquisition is the best option going forward.

This is easier to achieve in a more strategic merger, for example a move to integrate units offering complementary services, such as combining women's and children's services. The resulting merger would clearly have a different shared identity as it would be offering different services.

In a situation where a larger hospital or trust merges with a smaller one, particularly in the case of acquisitions, the post-merger culture, identity and operating model is too often based on an enhanced version of the acquiring organisation's model.

Some might hold this up as a good example of success, but I'd argue that this is merely a façade of the previous organisation and very little real integration has actually taken place.

When trusts merge which are still based in geographically different locations, integration is much more difficult to achieve. In these cases, simply changing the name or the make-up of the board isn't going to bring them together. True integration, and acceptance that it is a single entity, will probably only take place if you mix the staff over the two sites; a measure which is likely to meet with some resistance.

I think it's essential that both the merging organisations acknowledge that the outcome of the merger creates a combined identity and culture which is new for both of them. Some of its values may be the same as one or both of the pre-merger organisations, but it is not enough to simply change the name or board members and carry on as before. Real communication, sharing of resources, and mixing of staff between sites are necessary to move towards a shared vision and allow for complete cultural integration.

" it is not enough to simply change the name or board members and carry on as before

Within the NHS, bringing people together barely features at the right time within the acquisition process. It's either done as a token gesture at the end or the focus will be on job security, rather than what life will be like working together. The net result of this is that people feel insecure and they leave, which exacerbates the problems of the failing Trust, as in the Stafford merger, where they were forced to rely heavily on agency workers.

So organisation A adds organisation B and together they become organisation A+, rather than truly merging to become organisation C.

For the staff who are part of the acquiring organisation, the impact on their working life can be minimal, as they experience little more than a name change while going about their business in the same way on the same site.

Question Three

Who really drives change?

While there is little argument that change is necessary if the NHS is to survive, the best way to implement that change, and agree who should drive that change, is less certain. The recent Challenge Top Down Change campaign within the NHS supports a bottom-up approach, a strategy that is supported by Stephen Dorrell. By contrast, Matthew Custance argues firmly in favour of a top-down led approach. Beccy Fenton explains why the health service should plot a route somewhere between the two.

Stephen Dorrell

Stephen is an external advisor to KPMG's healthcare sector and a longstanding member of the Conservative party. Stephen wanted to become a politician from a young age and upon his election to the House of Commons in 1979, aged 27, he was known as the Baby of the House of Commons. In 1990, Margaret Thatcher made Stephen a junior Minister for Health due to his managerial expertise. Under John Major's government, he became Secretary of State for Health (1995 – 1997). He enjoys spending his free time with his wife and four children.

> If I was put in charge of the NHS for 24 hours, my first hour would be spent on strengthening joined-up commissioning between health and social care.

An organisation-wide commitment to embrace change is paramount

Medieval humanity is supposed to have believed that the status quo was permanent. Leaving aside the historical argument (were human beings ever so compliant?) the undoubted lesson of the centuries since the Renaissance is that a process of continuous change lies at the heart of human progress. Societies and institutions which try to insulate themselves from the change process quickly render themselves obsolete.

All organisations need to challenge themselves to be open to new ideas and new opportunities. Change is not an event which is completed; it is a way of life which is continuous and successful organisations aspire to adopt faster than their peers.

and the wishes of the individuals and communities who rely on their services.

Over-centralised organisations fail because they voluntarily disable themselves from responding to these challenges. By centralising decision making they guarantee that decision-makers are divorced from the sources of the information they need to make optimal decisions.

Key messages, which frontline staff understand, are "lost in translation" as they wend their way through uncomprehending tiers of middle management. Furthermore the over-centralised organisation embraces two additional risks; by over-emphasising the value of orthodoxy it systematically undervalues

of the organisation with clarity and appoint local leadership which is committed to deliver those objectives. Then it must provide local leadership with the space to act. Failure to observe this basic rule reduces local leadership to mere agency. Managers become courtiers whose concern is to "manage upwards" rather than deliver the objectives of the organisation.

Most importantly, senior management should recognise that in a large organisation diversity is often evidence of challenge and innovation. Their objective should not be to suppress diversity but to celebrate innovation while maintaining a focus on outcomes and acting to challenge outcomes which do not match the best.

It is ironic but true that healthcare organisations, which explore the frontiers of biological science, sometimes have a poor understanding of the principle of evolution.

Maybe some of their leaders should re-read Darwin!

> the controlling manager always underestimates the extent to which central control disables local initiative.

Change in healthcare is the result of many drivers. Every new treatment creates changed patterns of service, and changed patterns of demand. Furthermore healthcare, like all other activities, is affected by broader technological change (e.g. in information technology) as well as by changing consumer expectations and changing social attitudes.

Faced with these complex challenges the key requirement is to ensure that healthcare organisations understand the changing world in which they work.

They need to understand the many technological influences on healthcare, but they also need to understand the needs

the wishes of the different individuals and communities it serves and it fortifies itself against disruptive new ideas.

Management may try to invest in improved internal communications to combat these effects, but in doing so it is missing the point. Quite apart from the fact that the perfect conductor is unknown to physics, and there is certainly no human reporting system which is capable of transmitting information without distorting it, the controlling manager always underestimates the extent to which central control disables local initiative.

Instead of seeking ever more control, management should define the objectives

> My healthcare-related heroine has to be the founder of modern nursing, Florence Nightingale. The Nightingale model of care and compassion has brought so much to our health service.

by Beccy Fenton

82%

of respondents to *Wie doet het met wie in de zorg?,* KPMG's 2014 study of Dutch hospitals undertaking collaboration, stated that they had yet to realise the intended benefits of the mergers their organisations were undertaking.

Top-down and bottom-up approaches must meet in the middle

Successful collaboration between large healthcare organisations will always require both top-down and bottom-up management. The leadership needs to set out the vision and the objectives of the collaboration, but the front line must be given the role of driving the delivery. You cannot have one without the other.

The NHS has always had a top-down culture. Because of this, staff do not know another way of working.

> Persisting exclusively with one approach will mean the blind end up leading the blind.

Regulation is partly responsible for the top-down mind set. When NHS regulators monitor an organisation's performance, they first feed back to the board. The leadership are then tasked with kicking off a top-down cascade, which moves that information down a hierarchical funnel to directors, then directors to managers, then managers to ward managers and so on.

While this might seem like a logical approach to information sharing, it does little to engage the front line. Unlike those in the boardroom, staff working in the wards are the ones who have first-hand knowledge of how the organisation operates and how other services can be integrated.

This needs to be acknowledged by the leadership or they risk front-line staff feeling powerless to deliver better services or the benefits of a particular merger or acquisition.

For me, this is the problem with a pure top-down approach. After all, without the full support of those on the ground and their specialist knowledge and insight, what would they be left with?

That said, leadership should still be responsible for setting out the vision and objectives of an organisation after a merger or acquisition. They hold an unrivalled view across the entire organisation that those on the front line will never have. In some NHS institutions, this front line is thousands of people. Asking them to have a bird's eye view, coupled with a demanding day job, would be impossible.

That's why the answer can only be a middle ground between top-down and bottom-up management. A mixed approach gives you the benefit of top-down clarity of vision, strategic thinking and a compelling reason for collaborating, and the bottom-up expertise in implementing the strategy. Persisting exclusively with one approach will mean the blind end up leading the blind.

by Matthew Custance

Change needs a senior champion

Healthcare collaboration requires serious investment and organisational commitment. That can only happen when the management team champion the collaboration.

Implementing change successfully, either within the NHS or anywhere else, requires a particular type of person. They need to be energised, passionate people with a driving vision and also senior enough to command respect from people both within the organisation and around it, including regulators.

> **This idea that bottom up change just magically blossoms simply doesn't work.**

Sir Robert Naylor, Chief Executive of University College Hospital London, is recognised as a very powerful figure who has sponsored change, taking his hospital from the brink of financial failure to to being one of the most successful trusts in the country.

Equally the Board of West Middlesex hospital was incredibly brave in recognising they weren't financially sustainable in the long run and putting their hand up before it failed. The leadership demonstrated by the Chairman, Chief Executive and the rest of the management team in making that decision was inspiring, and it couldn't have come from anywhere but the top.

Bottom up change does matter and good leaders listen, but successful leaders inspire, persist and drive through. It is naive to think that change will happen without a senior champion.

Think about a nurse who wants to change the model of care on her ward. She's only going to be able to do that with the support of a strong sponsor further up the chain, such as a matron or the director of nursing.

It is important to encourage innovation on the ground, but strong top down leadership is essential when deciding which initiatives to back and which are undeliverable. This idea that bottom up change just magically blossoms simply doesn't work. All this does is lead to inconsistent practice and as research shows, poor patient outcomes.

For example, there's a golden rule that if you present at hospital with a heart attack, you should be given aspirin. Despite this, studies between 2002 and 2012 show that anywhere from 5-15% of patients did not receive this treatment.

Conversely, one hospital in a not particularly affluent part of Korea achieves heart surgery outcomes far ahead of the best hospitals in the West. How do they achieve this? By taking the research on best practice and implementing it without deviation. The patient outcomes speak for themselves.

> **Any change process requires supportive, inspiring leadership.**

A similarly-standardised approach is used in the Ramsay group of hospitals in Australia. They use similar clinical equipment, prosthetics, drugs, methodologies, even down to linens and bed layouts, to provide a consistent clinical approach and patient experience.

I think this strictly imposed accepted practice is the way to achieve the best

patient outcomes, and that's something that can only come from the top down.

Another interesting, and possibly more achievable, model for the NHS is the Premier group in the US. A collaboration of about 100 individual not-for-profit hospitals worked out a series of best practice guidelines to promote quality, around 10 simple protocols per clinical area. This helps lead to standardisation while managing the level of top-down instruction.

Premier trained the staff in implementing the protocols and also audited their compliance levels. So as in the NHS, you have individual organisations working collaboratively to achieve positive patient outcomes. This is a model that we could successfully adopt in this country.

Standardisation is important, but it's only part of the story. Any change process requires supportive, inspiring leadership. This extends to cultural attitudes and vision, such as the bold, anti-bullying stance recently taken by the head of the Australian Army.

This need for leadership, combined with standardisation, is why top down is really the only way forward for healthcare collaboration in the NHS.

What next?

So where does this leave healthcare collaboration in the NHS? My team and I have looked at the myths, the lessons to be learned and the right way to drive change. Now we examine at the best forms of collaboration.

Matthew Custance dissects the different methods of collaboration within the NHS and rates their effectiveness. Beccy Fenton advocates greater standardisation, which would allow for more collaboration in the future. Roberta Carter puts forward the idea that public backing for collaboration is more important than the chosen method.

Roberta Carter

Roberta is a partner and leads KPMG's UK integration Advisory practice. With over 15 years' experience, she advises clients on pre-deal strategy, post deal integration and separation planning and execution. Roberta has particular expertise in managing the people, culture and communications aspects of deals. She came to the UK in 1992 and settled in Harrow, where she tried to understand options for finding a GP by ringing round the list of 11 options provided by the local health authority and asking the practice nurse for the doctor's qualifications and general information. After a series of predictable reactions, she did finally succeed in arranging an 'interview' with the GP who also looked after the boy's school, who apparently was willing to entertain such a discussion because he was used to pushy Harrovian parents!

> I came to England in the early 90's working on an IT project for the NHS. My US team sent over an 8 inch floppy disk with a program bug fix and when I collected it from the hospital basement computer room, someone had stapled a note to it. Today, this would be a bit like giving your mobile phone a bath and expecting it to still work! Thankfully, NHS use of IT has come on a long way since then!

NHS trusts should focus on the reasons for collaboration

NHS Trusts have a much greater chance of collaborating successfully if they focus on why they are working together and only then worry about how to structure the new entity.

Too many NHS healthcare mergers were failures in the 1990s for that very reason. In many cases, hospital administrators simply grafted together two management structures, and only later brought together back-office functions. In some cases, the divisions between distinct front-line services remain visible to this day.

These were often publicly-mandated mergers, motivated for political reasons. By contrast, today's successful collaborations have a compelling clinical rationale at their core, underpinned by commercial and financial rigour.

> In the successful deals I've worked on, in both the public and private sector, the strategic rationale has always been clear.

I'm glad to say an increasing number of collaborating trusts are getting the message - perhaps because they have to. NHS staff are working under far greater pressure now than 20 years ago. Budgets are stretched and the need to be more efficient and streamlined is more urgent.

The logic of collaboration, and the need to make it a success, is compelling. In the successful deals I've worked on, in both the public and private sector, the strategic rationale has always been clear.

> Leaders must make sure they properly articulate why collaboration is in the public interest

The NHS is one of the sacred cows of British politics and any change will inevitably face entrenched positions, such as political opposition and scepticism from clinicians who may not understand the benefits for patients. We all instinctively oppose change and want to protect local services. Even as hundreds suffered poor care at the Mid Staffordshire trust, people were waving 'Save Our Hospital' banners outside. Leaders must make sure they properly articulate why collaboration is in the public interest and ensure they have backing from clinicians.

Once trusts have decided to collaborate, they need to do so whole-heartedly and at every level. For that reason I see mergers – rather than joint ventures or alliances – as the most successful form of collaboration.

Joint ventures might endure for decades, but neither party is fully committed. The merger model is far more comprehensive and the best way to achieve big transformational change.

Mergers offer organisations synergies, so duplication and overlap are stripped out. More importantly, they bring together services that might previously have been provided by a number of organisations, giving doctors and nurses greater consistency and control across patient pathways.

Whatever the form of collaboration, its success depends on integrating information and ensuring all clinicians have complete access to their patients' holistic care plans and records. While investing in IT might seem less exciting than M&A, it is nonetheless a fundamental enabler for efficiency and patient safety. It also makes it easier to move activity out of hospitals and into the community, the home, a GP surgery or elsewhere.

The NHS is already very skilled at collaborating across boundaries such as the Academic Health Science Centres and cancer networks. But if trusts are trying to drive transformational change then a merger will produce results much faster. In an environment of ever greater demand and smaller budgets, properly thought through collaboration is essential to deliver higher-quality healthcare.

by Beccy Fenton

NHS practice must be standardised for collaboration to work

Financial sustainability, clinical integration, and operational and clinical performance are the top three reasons for collaboration within the NHS.

Hospital mergers can be very helpful in terms of implementing economies of scale, reconfiguring clinical services to improve quality and safety, or stabilising a financially failing trust. Mergers also enable the transfer of good practice from the leadership and management team of the acquiring trust.

This transfer is not necessarily straightforward for a number of reasons, the main one being the lack of standardisation and codification of the way things are done in NHS hospitals.

The NHS, and medical profession in general, has a large degree of autonomy which drives innovation. This has led to medical advances in treatments driven by entrepreneurial clinicians who want to improve their services.

> **I believe you can achieve a balance between innovation and standardisation.**

Entrepreneurial culture permeates across organisations into management as well, and runs counter to the idea of standardisation which you might find in, say, manufacturing industries.

As a result, hospitals tend to be reliant on capable individuals running a tight ship. However these individuals often end up firefighting operational pressures on a daily basis, in part due to the fact that standard

ways of working aren't properly embedded as they would be in another industry.

I just don't think it's possible for good managers or clinical leaders to then replicate what they're doing across more than two or more sites. The lack of standardisation and codification means managers have to inject a significant amount of personal effort into running things and there just isn't enough physical capacity to go round. Staff end up spreading themselves too thinly and performance is compromised.

> **The adoption of a standardised...methodology would enable the NHS to deliver far greater value for money.**

It is only by balancing this entrepreneurial model, with a greater degree of standardisation that collaboration through the concept of hospital chains could work in the NHS.

I'd argue the adoption of lean continuous improvement processes and tools, which require a high degree of standardisation, would allow for the system to codify good practice, improve the quality and productivity of processes and be run in a much more effective way. The NHS can learn from the many examples in the private sector, such as Toyota and Jaguar Land Rover.

In addition to standardisation, another of the founding principles of lean continuous improvement, is front-line empowerment – giving people the skills to operate within standards. If those standards aren't achieving the best results for patients or staff, or value for money, then the staff are skilled and empowered to improve them.

In that way there's a systematic way of making improvements which can still support the drive for innovation. I believe you can achieve a balance between innovation and standardisation.

Implementing these changes within the NHS would require a total overhaul of the way it currently operates. It would need buy in and belief from the leadership to succeed.

The NHS needs to look at examples from other industries in the private sector as

well as different healthcare models in other countries, to see what is possible. There are effective examples of multi-site chains in healthcare, where individual organisations work to a standardised model.

None of this is straightforward, and it will require further research and investment at a national level, possibly being trialled in some high-performing organisations which have already started to head in this direction. The adoption of a standardised lean, continuous improvement methodology would enable the NHS to deliver far greater value for money, improved quality and higher staff morale.

> I chose to work in healthcare because of the opportunity to make a difference to something that touches millions of people's lives, rather than exclusively making money for shareholders.

by Matthew Custance

Mergers are the strongest model for NHS collaboration

The beauty of the merger process is that by tying two organisations together you remove the possibility of either party walking away. This is why I think imposing a single management structure through a merger is the form of collaboration that stands the best chance of success in an NHS environment.

It is never going to be easy to get two NHS organisations to work together. Size matters, and NHS hospital trusts employ thousands of people, all of whom need to engage with a process that impacts their day to day lives.

Long-term change will only succeed if there is some mechanism to lock the parties into delivering that change. The first responsibility of any stressed NHS executive (that's all of them) is to his or her own organisation. If a collaboration is not beneficial to them, it will quickly be abandoned.

The attempt by commissioners in the Midlands to jointly procure community pathology is one of many attempts to reconfigure the health economy that have fallen victim to this. It simply isn't possible to sell a financial loss to stakeholders or board members, even if it's only short-term.

> If you have invested scarce time and money, you need to be protected

Every NHS organisation faces the challenge of scarce resources, including their senior management time. Executives have to make major decisions and look at plans for collaboration in whatever time is left, after dealing with their regular heavy workload. So nothing happens quickly.

I've spent most of the time praising the NHS staff and don't want this quote to come across like I see them as moaning time-wasters, it is for two organisations to pursue a project together over a sustained period.

> With only an informal agreement, there's a strong risk of one partner being left holding the baby.

If a merger is not possible, the next best option is to create a shared responsibility through a joint venture. This creates a formal arrangement between two parties, and it forces discussion on collaboration. It might sound strange, but getting time in senior people's diaries is so difficult, that forcing them to meet really is a substantial benefit.

Joint ventures are a simple way of regulating collaboration. There are a number between NHS and private bodies to help with estates management or cost reduction. It was only with the creation of foundation trusts in the early 2000s that JVs became possible, but their effectiveness is already clear. A good example is the Fulham Road collaboration, where the Brompton, Marsden and Chelsea & Westminster trusts have agreed to share back office functions such as HR and accounting.

If a JV or merger isn't possible, or practical, the next option is a legally-binding contract. There are lots of examples of this type of collaboration both within the private sector and in the form of service level agreements in place throughout the NHS.

It may seem cynical, but if you have invested scarce time and money, you need to be protected by an agreement that ensures your partners contribute with you. The NHS environment is so fast-moving that the circumstances that led to the creation of

the contract are unlikely to last. With only an informal agreement, there's a strong risk of one partner being left holding the baby.

NHS managers are monitored and managed in such a way that it is more urgent for them to respond to failure than to take an opportunity to make a good service, great. This means they tend to go into collaborations to solve a specific problem.

The system is designed to make the manager's original organisation their primary responsibility, not an intangible system-wide benefit. Thus the stronger the ties that bind collaborating organisations, the greater the chance of success.

Conclusion

Over the years NHS organisations have become ever more autonomous. Many have discovered new and innovative ways of working and an entrepreneurial approach that has improved services for patients.

However, there is a growing perception that the benefits of this approach may now be eclipsed by the potential gains from increased collaboration between NHS organisations.

I think that the learning and success achieved by pioneering organisations must be shared.

This means trusting the success of colleagues within the NHS and adopting what works.

Ultimately, collaboration isn't new to us. As Roberta points out, as far as the rest of the world is concerned, our organisations are already collaborating within a chain under a single brand, "the NHS". If we continue to promote this way of working, I believe the NHS will carry on making history.

Andrew Hine

"If you are going to go down the road of formal collaboration, as with any problem in life, you have three options: do it, don't do it or fake it. To my mind, there are too many types of collaboration, alliances, networks and informal agreements that are versions of faking it. Hospital mergers will ultimately fail if all they do is change management teams and put a new nameplate over the entrance."

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