



Cass Business School
CITY UNIVERSITY LONDON



Improvement

Mergers in the NHS: lessons learnt and recommendations

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About NHS Improvement

NHS Improvement is responsible for overseeing foundation trusts, NHS trusts and independent providers. We offer the support these providers need to give patients consistently safe, high quality, compassionate care within local health systems that are financially sustainable. By holding providers to account and, where necessary, intervening, we help the NHS to meet its short-term challenges and secure its future.

NHS Improvement is the operational name for the organisation that brings together Monitor, NHS Trust Development Authority, Patient Safety, the National Reporting and Learning System, the Advancing Change team and the Intensive Support Teams.

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1. Introduction

This report is based on research carried out by Cass Business School on behalf of NHS Improvement,¹ reviewing seven NHS mergers² involving foundation trusts that acquired another foundation trust or NHS trust between 2007 and 2014. Most of the transactions were between district general hospitals and the target organisation was slightly smaller than the acquiring trust in revenue and number of employees.

We review findings and recommendations distilled from 37 interviews with board members and senior executives against a literature review of best practice evidence (principally related to private-sector mergers) where this was available and relevant.

The findings are set out in the order of stages in NHS transactions, from strategy through pre-deal and due diligence, negotiation and integration, to realising the benefits, and followed by sections on leadership, culture and the regulatory process.

Figure 1 shows an overview of the mergers and acquisitions process. Table 1 on page 6 shows a summary of the demographics of the foundation trusts and trusts involved. We plan to update this information every year. Annex 1 contains a one-page summary of the recommendations to boards.

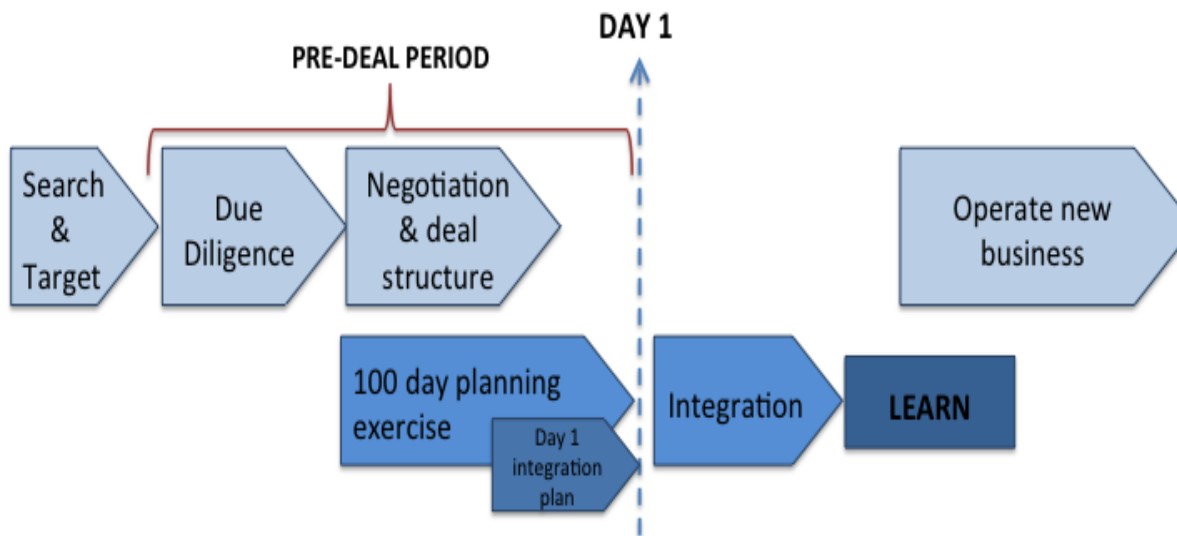
Alongside this report we are publishing [more in-depth work on realising the benefits of mergers](#),³ reviewing a broader set of past mergers including mergers of equals as well as acquisitions of failing trusts. This work will draw out the lessons for those considering a merger about the types of benefit that may arise as a result of a merger, whether a merger is the best way of achieving those benefits, and factors that can affect the delivery and timing of those benefits.

¹ NHS Improvement is the operational name for the organisation that brings together Monitor, NHS Trust Development Authority, Patient Safety, the National Reporting and Learning System, the Advancing Change team and the Intensive Support Teams.

² By merger we mean both mergers and acquisitions.

³ [Improvements NHS providers have achieved through mergers](#) and [Factors affecting the success of NHS mergers](#) available at <https://improvement.nhs.uk/resources/how-make-nhs-mergers-work-better-patients>

Figure 1: The mergers and acquisitions process



Danny Davis (2012) M&A Overview. In *M&A Integration: How To Do It. Planning And Delivering M&A Integration For Business Success*, John Wiley & Sons Ltd, UK: 3–15

Table 1: Key trust demographics

| | | | | | | | |
|----------------------------------|--|---|--|--|---|--|---------------------------------------|
| Acquiring organisation | Royal Free London NHS Foundation Trust | Basingstoke & North Hampshire NHS Foundation Trust | Frimley Park Hospital NHS Foundation Trust | Norfolk and Waveney Mental Health Foundation Trust | York Teaching Hospital NHS Foundation Trust | King's College Hospital NHS Foundation Trust | Heart of England NHS Foundation Trust |
| Transaction type | Acquisition | Acquisition | Acquisition | Acquisition | Acquisition | Acquisition | Acquisition |
| Transaction date | 1 July 2014 | 9 Jan 2012 | 1 Sep 2014 | 1 Nov 2011 | 1 July 2012 | 1 Oct 2013 | 1 April 2007 |
| Revenue (turnover) | £570.2m | £162.6m | £280m | £134.9m | £247m | £679.3m | £281.2m |
| Financial position | Surplus | Surplus | Surplus | Surplus | Surplus | Surplus | Surplus |
| Beds | 543 beds | 426 beds | 750 beds | 25 sites | 804 beds | 946 beds | 1,100 beds |
| Employees | 5,479 | 2,418 | 4,021 | 2,396 | 4,103 | 6,714 | 5,438 |
| Population served | 891,000 | 300,000 | 400,000 | 878,000 | 350,000 | 700,000 | 1,100,000 |
| Type of clinical services | DGH & some specialist services | DGH | DGH & hyper acute services | Mental health | DGH & community/rehab | DGH/tertiary/teaching hospital | DGH |
| Trust quality | Considered well-led | Considered well-led | Considered well-led | Considered well-led | Considered well-led | Considered well-led | Considered well-led |
| Post-merger organisation | Royal Free London Foundation Trust | Hampshire Hospitals NHS Foundation Trust | Frimley Health NHS Foundation Trust | Norfolk and Suffolk Foundation Trust | York Teaching Hospital NHS Foundation Trust | King's College Hospital NHS Foundation Trust | Heart of England NHS Foundation Trust |
| Target organisation | Barnet & Chase Farm Hospitals | Winchester & Eastleigh NHS Trust | Heatherwood and Wexham Park Hospitals Foundation Trust | Suffolk NHS Trust | Scarborough & North East Yorkshire Healthcare NHS Trust | Princess Royal University Hospital, Bromley | Good Hope Hospital |
| Income | £326.3m | £146.7m | £232.3m | £87.4m | £121m | £186.5m | £113.5m |
| Financial position | £16.9m deficit. £49.51m deficit projected (normalised) over the next 5 years if no merger. Notable to cut more than £30.35m of cost. | Break even only because of non-recurrent funding solutions. £5.4m support from SHA in 2011 and working capital loan of £6.5m from DH in 2011. | Deficit of £9.6m in 13/14 (underlying deficit of £18.5m after adjusting for non-recurrent CIP, CQC costs, commissioner support and winter pressure funding). | Break even | Surplus of £1.9m | £23m deficit in 12/13 | £6.3m deficit in 05/06 |
| Beds | 522 beds | 423 beds | 610 beds | 60 sites | 328 beds | 527 beds | 550 beds |
| Employees | 3,834 | 2,180 | 3,517 | 1,759 | 1,931 | 2,458 | 2,439 |
| Population served | 500,000+ in Barnet, Enfield and some of Hertfordshire | 300,000 | 450,000 | 670,000 | 180,000 | c.306,000 | North Birmingham (Birmingham – 1.1m) |
| Type of clinical services | Primarily acute trust with some community services | DGH | DGH | Mental health | DGH | DGH | DGH |

2. Strategic rationale

2.1. Interview findings

Mergers and acquisitions literature refers to the initial strategic stage as ‘Search and target’. In the NHS, however, there is usually no search, so this report focuses on the target. All the transactions studied were acquisitions of underperforming or failing NHS or foundation trusts by well-performing foundation trusts based on clinical or financial criteria. The interviewees defined clinical failure as a failed Care Quality Commission (CQC) inspection and/or inability to achieve targets for national clinical outcomes. They defined financial failure as a deficit and inability to deliver cost improvement programmes (CIP). The two main reasons quoted for the acquisition of a target were (in order of frequency):

- The target organisation (or the Department of Health (DH)) was looking for a trust to merge with or be acquired by because it was unable to achieve foundation trust status independently due to insufficient clinical quality and/or poor financial control.
- The regulators put the target organisation into special measures because of poor clinical quality and safety and/or poor financial control.

In most instances it was the strategic health authority (SHA), DH or target trust board that approached the acquiring trusts.

“Non-FTs [foundation trusts] were being assessed for their route to FT and they were deemed to not have [a] route independently, so they almost became available on the market.”

Interviewees from the acquiring trusts said that their strategic rationale included one or more of the following reasons, in order of importance:

- help the local health economy by improving the quality of services for patients where these were sub-standard and preserving them
- increase their market share to achieve critical mass in clinical services
- increase the size of the organisation to achieve economies of scale for long-term financial sustainability
- defensive: avoid erosion of their market share if another provider (a public or private organisation) took over the target
- increase their reputation and, as a result, their ability to attract and retain good staff.

“It was widely known that [hospital name] was a failed or a failing trust. It was never going to get FT status. The initial approach came from the SHA, which of

course was in place at that time... The SHA approached us with a view to take over [hospital name] in order to save [hospital name] ... save services to the community of [the area]... That was the...trigger... It was also an opportunity to consolidate services, to grow services, which means you can attract better quality consultants and improve services.”

Although participants cited several reasons for merging, the main reason in all cases was to help the local health economy by preserving services and improving quality for patients.

The transaction documentation showed that although the main reason for the acquisitions was to improve the quality of poorly performing trusts, the articulated benefits of integration were mainly based on financial savings from economies of scale and synergies. There was an underlying assumption that a takeover would resolve quality and safety issues but no clear articulation (in the integration plans) of how this would occur or of the specific resources allocated to quality improvement.

While funding was allocated for the integration of services, no resources were allocated specifically to the improvement of clinical quality. This may relate to the finding (see later) that most trusts underestimated the effort required to implement change in clinical services in their plans.

2.2. Best practice review

Outside the NHS it is well known that up to 60% of all mergers fail to deliver the planned benefits, with some authors quoting a failure rate as high as 90% (Clark and Mills, 2013; Bauer and Matzler, 2014). However, the odds of success for small to medium-sized enterprise acquisitions are higher on average (45%) when the target organisation is in the same industry segment, or a very similar one, and when it is smaller than its acquirer in terms of revenue (Bauer and Matzler, 2014).

This frequently happens in NHS acquisitions, so the chances of creating value may be higher than average (Clark and Mills, 2013). While many authors emphasise the importance of strategic similarity as a factor for enhancing value creation post-merger, complementary differences have also been found to be crucial (Dash et al, 2012). The hospital trusts in this study showed both of these elements to an extent, so could be considered to have a strategic fit.

The transaction rationale described by interviewees was largely consistent with the evidence, which states that healthcare mergers frequently aim to improve financial efficiency to secure the viability of services, improve clinical quality and increase staff recruitment and retention (Protopsaltis et al, 2003). This research stresses that the rationale for a merger needs to be based on a clear, objective appraisal of the financial and clinical benefits that the transaction would bring to the organisations or to the wider health economy (Dash et al, 2012).

The literature states that the benefits sought from a merger should be clearly understood and used as a basis for integration planning (Venema, 2015; Davis, 2012). This connection between the aims of the merger and the integration process has been linked to merger success (Bauer and Matzler, 2014).

Moreover, in hospital mergers clarifying how the merger will improve clinical care is essential to ensure clinical staff and stakeholder engagement (Dash et al, 2012).

Recommendations

1. Make sure the aims of the merger are well understood at the outset by all parties involved, including both financial and clinical benefits.
2. Make sure care quality benefits are articulated and funded as well as financial ones and include the investment required to increase clinical quality in a failing trust (a key reason for most NHS acquisitions).
3. Build all expected benefits into the integration plan and be very clear about the specific changes needed to realise these benefits.

3. The pre-deal period

3.1. Interview findings

The 'pre-deal' period refers to the time between when the acquiring trust is recognised as the preferred bidder and the transaction (closing) date. In the trusts surveyed, this period was reported to vary between six months and two years, with most lasting between 15 and 24 months.

Overall respondents suggested that two years was too long and transactions should ideally be completed in six to twelve months to reduce the period of uncertainty for staff and avoid increases in the costs associated with integration. One respondent said

“Two years was too long... Six months is too short... There is probably a sweet spot in between. Nine months to 15 months is probably a sweet spot.”

The main reason quoted for the present long pre-deal periods was the time taken for the regulatory, commissioning and other stakeholder approvals required by the process.

One respondent reported that it took:

“19 levels of approvals... 53 board meetings and sub-committees... nine sets of advisers.”

NHS Improvement's process can take up to three to four months. Interviewees in one transaction reported that approval from the Competition and Markets Authority (CMA) had taken three to four months. Interviewees also described clinical commissioning group (CCG) approvals as having delayed the process.

Although respondents reported potential negative effects from a longer pre-deal period, such as increased costs and prolonged uncertainty for staff, this period was also seen as an opportunity to get to know the target before the transaction and to start integration activities. Getting to know the target and starting integration activities should be done with the competition rules (relating to interaction between trusts in the pre-deal period) in mind, where relevant.

In most transactions, the chief executive or an executive board member/senior manager from the acquiring trust worked at the target organisation during this pre-deal period. This was reported to be useful for understanding the target and gathering 'soft' information, which would minimise surprises after the deal. However, it must be noted that most of these supportive senior leadership appointments were put in place to support the failing trust and were not related to the acquisition. We frequently provide advice on these kinds of arrangements to ensure that the necessary safeguards are in place from a competition perspective.

In line with competition rules about exchanges of commercially valuable information in this pre-deal period, there was limited pre-deal information-sharing with the target organisation before CMA approval. Once approval was granted, most acquiring trusts reported information-sharing and working more closely with the target to start integration in preparation for the takeover. This preparation took many different forms, including:

- a shadow management structure within the target organisation
- non-executive directors shadowing board meetings
- directors and senior staff entering the organisation in a supporting role, eg a director of nursing supporting improvement of clinical governance
- HR director/team working to support the local team in the delivery of restructuring consultations and culture work.

Although initiating these activities within the target organisation before the deal seemed risky when it was not certain whether or not the deal would go through (eg without proper competition safeguards yet in place, where there were competition concerns), respondents reported that even if the deals had not happened, the target (failing) organisations would have benefited from this period of improved management:

“It [the pre-deal period] allowed relationships to be established less from an authoritative perspective and more from a support perspective.”

“Day 1 [was] business as usual because we had 12 months pre- where we [were] gradually integrating elements as we worked through it.”

Therefore, there were benefits to early access to the target organisation in introducing a new management and governance culture before full management control was enforced.

3.2. Best practice review

The dynamics of the pre-deal period seem to be one of the key differences between private-sector transactions and NHS transactions. In the private sector this period spans the ‘announcement’ date to closing the deal. In the NHS, the announcement date can be considered to be when the acquirer is confirmed as the preferred bidder.

In the private sector this period is typically six to nine months from the day on which the acquirer expresses interest in the target. In the NHS, however, the process takes longer because of the large number of regulatory, commissioner and other stakeholder approvals required.

Therefore, a balance must be struck between speed and detail. While each transaction had different challenges, the pace of the regulatory process was the most important (common) variable, which could be influenced to shorten this period.

Developing a realistic integration plan which ensures value from the transaction depends on access to key information about the target organisation during due diligence (Protiviti, 2014). In the private sector, this information is central to pricing and the ultimate decision on whether or not to take over the target (Protiviti, 2014). Similarly, in the NHS this period is key to understanding transaction costs.

However, information-sharing is limited by competition legislation, which forbids access to commercially sensitive information before the deal is signed (Protiviti, 2014; Competition and Markets Authority, 2014). In the private sector, this is increasingly being managed using ‘clean teams’ (AON Corporation, 2010). Clean teams usually consist of individuals from both organisations, who are given access to certain information and work to strict protocols. They collect information about the target and present it to the leadership in a summary format which is allowed by competition law to inform decision-making (AON Corporation, 2010).

In the NHS, clean teams have not been used. However, we have advised trusts on clean teams, non-disclosure agreements and how to manage the risks around information sharing so that they are able to engage with each other at an early stage. Once the CMA has approved the deal, trusts have significantly more freedom in what they can and cannot do before the transaction closing. Since most acquisitions involve failing trusts, time is critical to ensure clinical safety. In fact, respondents recommended that a balance needs to be struck between anti-competitive behaviour and benefits for patients.

Getting to know the target and starting integration activities should be done with the competition rules (relating to interaction between trusts in the pre-deal period) in mind, where relevant.

There is no direct research into the impact of public-sector secondments or management contracts on mergers and acquisitions success. However, Cai and Sevilir (2011) found that mergers between companies that have board 'connections' are more likely to be successful due to a better understanding of each other's operations and corporate culture. In practice, we frequently provide advice on these kinds of arrangements to ensure that the necessary safeguards are in place from a competition perspective.

Access to the target organisation was seen as a key advantage and vital for delivering detailed due diligence leading to well-informed integration plans. Although a longer period of uncertainty can damage organisational effectiveness, a lengthier due diligence process has been linked to increased success in mergers and acquisitions for the acquiring organisation (Anon, 2013). The pre-deal period should therefore be used to deliver more detailed due diligence to inform integration planning, in line with what is permissible under the competition rules.

Access to the target in the pre-deal period needs to be carefully managed from a competition perspective but there are several safeguards that can be put in place to mitigate the competition risks including:

- establishing a clean team made up of personnel who are not involved in strategic decision-making to review sensitive information
- having a non-disclosure agreement to protect against the disclosure of confidential information and how confidential information is used in this period
- ensuring that any information exchanged is returned or destroyed if the transaction does not go ahead.

Organisations should seek advice on the competition implications of early access to the target so that the associated benefits can be realised within the competition rules. These safeguards are only needed where the trusts are seen as close alternatives to each other.

Recommendation

4. Get your own people working inside the target as early in the process as possible (in line with what is permissible under the competition rules). Once CMA approval has been obtained there are fewer restrictions on what the trusts can and cannot do. Secondments of members of the leadership team or management contracts have been useful in this regard. Shadowing of less senior clinical managers is also recommended.

4. Due diligence

4.1. Interview findings

The findings show that due diligence was frequently not comprehensive enough to ensure that there were no surprises after the transaction. Some interviewees felt that this was inevitable and that due diligence would never uncover all that needs to be known about the organisation being acquired.

“The thing about due diligence is it’s never enough ... that’s always going to be the case.”

Some, however, felt that aspects of the due diligence process could be improved. Where possible, shadowing the target organisation was an important opportunity to do this and much of the ‘soft’ information was obtained in this way.

Nevertheless, the trusts reported surprises and the need for more detailed clinical (operational) due diligence and that insufficient clinical due diligence was an issue. While the ‘headline’ financial and NHS outcome figures reviewed by consultancies were useful, more detailed clinical due diligence on, for example, waiting time targets was recommended.

Similarly, it was deemed desirable to understand how incidents, serious incidents and complaints were managed and reported in detail, rather than just numbers and high-level themes.

All respondents agreed that staff from NHS trusts and foundation trusts with relevant experience are better placed to understand the operational and clinical practices behind the clinical ‘headline figures’ than management consultancies. They suggested using such staff could avoid a number of typical problems discovered post transaction. The main issues reported, in order of frequency, were:

- worrying clinical practices that were not evident from ‘headline’ figures, such as waiting lists for second appointments for cancer
- a deterioration in the clinical outcomes observed once data collection and reporting improved post transaction

- the uncovering of poorly managed complaints relating to clinical incidents, which had to be re-opened.

Interviewees believed that a better understanding of data such as A&E waiting times, cancer waits and clinical incidents was also an important diagnostic for the issues faced by failing trusts. It would enable a better understanding of the effort and skills an acquiring trust would need to improve the performance of its target.

The respondents all agreed that legal and financial due diligence were best carried out by third-party firms that are experts in their respective fields. However, they thought different NHS organisations doing their own due diligence in relation to the same transaction was a waste of resources.

One respondent suggested creating a national procurement framework for legal due diligence to reduce the cost to the NHS of future transactions. In more recent transactions, participants reported using a shared due diligence process and also recommended its use in future transactions.

Most respondents therefore recommended a jointly procured due diligence process where information was shared transparently with all the parties involved. This was considered to be in the best interests of the local health economy as a whole, saving money by avoiding duplication. However it may not apply where there is only one bidder for the target organisation. This information sharing should be conducted in accordance with competition regulation as discussed in Section 3.

Interviewees reported increased costs involved in making pay bands and staffing levels even across organisations during integration. While staffing levels, pay band distribution and costs are considered as part of the due diligence and NHS Improvement review processes, the variation among services and the cost required to bring these in line were not factored into the costs of the transactions reviewed. Interviewees reported that the failing acquired trusts often had lower staffing levels and/or lower banded staff (mainly nurses) doing equivalent jobs, as well as higher vacancy rates, which led to increased staff costs after the deal.

Most trusts also carried out cultural due diligence, although the depth of analysis varied. Some trusts used national staff surveys (with a few extra questions), while others completed a more thorough analysis using workshops and/or interviews. Participants from some trusts used this information to monitor staff satisfaction while others used it in their decision-making:

“We had a big debate about did we change the name and actually the decision was no. So, one of the things that came through when we were doing the cultural [analysis]... – to take away the [hospital] name... – would have been seen as a negative thing... That community alignment was something they didn’t want to lose... It demonstrated that we respected those differences.”

Participants said that all acquiring trusts worked with staff to extend their organisational values to the target or develop new ones for the new organisation. Nonetheless, respondents from all trusts wished that they had done more to manage organisational culture (see Section 11 'Culture' for more detail).

4.2. Best practice review

Due diligence is the process of understanding the target organisation and usually focuses on financial and legal factors (Davis, 2012; Kusserow, 2013). Good due diligence is a key success factor in mergers and acquisitions transactions since surprises after an acquisition can result in failure to deliver the projected benefits (Davis, 2012). In the US healthcare sector, 25% of intended mergers do not go through due to findings uncovered by the due diligence process (Kusserow, 2013). However, mergers still fail due to surprises uncovered once the target has been acquired (Davis, 2012).

The vast majority of research on due diligence is from the private sector and tends to focus on financial data, legal issues, operational assets, deal pricing, market factors, marketing prospects, sales and strategy issues. As with many other industries, interviewees reported that due diligence in the NHS is mainly based on financial and legal elements, and is carried out by external firms. In addition, regulators require that governance arrangements are reviewed as part of the due diligence process (Galpin and Herndon, 2000; Ryan, 2010).

Galpin and Herndon (2000) stress the importance of delivering due diligence at every stage of the deal process and ensuring that it also includes three non-traditional components based around the ability of the two organisations to:

- achieve the level of integration required for synergies
- overcome cultural differences
- manage human capital risks.

Furthermore, they suggest the due diligence process should be used to challenge the projections and assumptions behind the rationale of the acquisition and consider the viability of the integration process. Studies of healthcare mergers in the US find that a lack of due diligence on regulatory compliance can result in significant costs if the target organisation turns out to be non-compliant post transaction (Anon, 1995; Kusserow, 2013).

In the NHS, major compliance issues with billing and core regulations are unlikely because of the heavy involvement of regulatory bodies, such as the Care Quality Commission and NHS Improvement, in the process. However, other factors, such as medical equipment maintenance, fire safety, infection control and adherence to minimum staffing levels, should be considered in the due diligence process since they have been reported as a cause of increased costs in the transactions reviewed.

Some industries have tools and checklists to guide the due diligence process. We provide an indicative due diligence list in our [transactions guidance](#) (Monitor 2015).⁴ Although these checklists can help ensure all the key aspects of due diligence are covered, due diligence should be an iterative process. It requires a tailored approach, which also investigates issues that are vital to the organisation and the specific transaction (Galpin and Herndon 2014; Ilsley, 1998; Monitor, 2015; Protiviti, 2014). It is therefore important to understand the root cause of the financial and/or clinical failures which underlie the transaction rationale behind the acquisition of a failing NHS trust.

Research indicates that it is not advisable to rely on data provided by the target (Ilsley, 1998). The accuracy of financial information is not usually a problem in NHS transactions since the figures are audited by third parties and available to regulatory bodies. However, projections cannot be verified and there may be other issues uncovered by the acquiring trusts, which raise the cost of quality improvement or integration (Ilsley, 1998). The information will be limited by the management's understanding of its own organisational issues, which may be unsatisfactory considering that the target is usually a failing hospital.

A growing body of literature stresses the importance of cultural factors in mergers and acquisitions and, therefore, the importance of cultural due diligence (Berry, 1983; Ilsley, 1998; Galpin and Herndon, 2000; Marks and Mirvis, 2011; Bauer and Matzler, 2014). There is a key role for human resources (HR) in the cultural due diligence and merger process. It should increase understanding and raise awareness of the issues that will require management both during the transaction itself and in the integration following (Galpin and Herndon, 2000). It therefore gives an idea of the effort that will be required to implement the required change (Galpin and Herndon, 2000).

There are several models of cultural management in the literature (Galpin and Herndon, 2000; Marks and Mirvis, 2011); they are reported in more detail in Section 11 'Culture'.

Recommendations

5. Ensure due diligence process covers all compliance issues including fire safety, equipment maintenance, adherence to minimum staffing levels and any other relevant areas.

⁴ *Supporting NHS providers: guidance on transactions for NHS foundation trusts*. Available at: www.gov.uk/government/publications/supporting-nhs-providers-considering-transactions-and-mergers

6. Deliver a detailed clinical due diligence process to understand the root cause behind headline figures and 'diagnose' key issues relevant to the specific transaction.
7. Merging parties should draw on the experience of other trusts to make sure clinical due diligence is sufficiently thorough to reveal the process and issues behind waiting times and infection control figures.
8. Merging parties should jointly commission due diligence for all parties transparently, with the aim of securing a transaction deal that is the best value for the local NHS health economy as a whole.
9. Identify preferred providers to deliver legal and other due diligence through the NHS procurement framework to ensure good value for money.
10. Use the pre-deal period to deliver more detailed due diligence to inform integration planning.

5. Negotiation and deal structure

5.1. Interview findings

Negotiating sufficient transaction funding was one of the interviewees' main recommendations. Although some participants reported having received the correct amount of transaction funding, others reported that funding was insufficient. They all stressed the importance of negotiating the correct funding. In most cases in which funding was insufficient, due diligence was reported to have missed key issues that turned out to be costly to the acquiring trust after the transaction, such as high estates repair costs and medical devices maintenance backlogs.

Although some trusts reported negotiating guarantees with DH in their deals, in some cases these were not sufficient to cover the costs uncovered after the transaction. Although interviewees recognised that at the time 80% of acute hospital foundation trusts in the UK were in deficit, some stated that the NHS economic climate was only partly to blame for their organisation's financial problems and that the transactions had turned out to be more costly than anticipated.

Respondents reported that risk from staff and patient litigation relating to incidents predating deals was well managed, with trusts securing liability clauses in their deals with the vendor.

5.2. Best practice review

In the private sector there is evidence of a strong link between correctly pricing a deal and the success of mergers and acquisitions (Goedhart et al, 2010). Mergers

and acquisitions premiums depend on two variables: the ability to achieve synergies and the price paid for them, so negotiating the correct price is key (Miles et al, 2014). In the NHS, trusts do not pay to acquire other trusts, but the balance between synergy investment and achievement is probably still crucial for success.

The literature indicates that, even in the private sector, integration budgets are underfunded by at least 5% (Miles et al, 2014). Understanding the potential for synergies and resourcing integration correctly is key to merger success (Davis, 2012).

Most interviewees in La Piana and Hayes' 2005 work on mergers and acquisitions in the non-profit sector (2005) found that 'transition funding' was not sufficient. When not-for-profit mergers fail, they cannot resort to solutions used in the private sector, eg price hikes or selling the acquired organisation (fully or partly) to recover losses. These options are not available because NHS tariffs are not set by each trust and closing services involves multiple stakeholder approvals, which are often denied because patients would have reduced access to services for patients.

Therefore, acquisitions in the NHS carry an inherent financial risk for the acquirer and negotiating the correct funding to support the acquisition is vital. It is also unsurprising that some respondents would not recommend NHS acquisitions to others because they saw the funding risks as too high.

Recommendations

11. Be disciplined in assessing transaction funding requirements as well as in spending decisions post transaction.

6. Integration planning

6.1. Integration planning: interview findings

Interviewees reported that all trusts used very similar methodologies to create their integration plans during the pre-deal period. All had developed Day 1 plans, 100-day plans and subsequent benefit realisation plans spanning two to five years after the transaction.

Most trusts reported significant input from big management consultancies in developing their integration plans although the feedback from respondents about the benefits of using them was variable. Some recommended doing the synergy planning internally and using consultancies for benchmarking and other supporting activities.

“You do need to do some benchmarking [using consultancies]. You do rely on the firms a bit too much [for] the synergy work... Do it yourself.”

Although all the trusts involved clinical staff in their integration planning to some extent, the reported level of involvement was varied. Some trusts only involved clinical directors and senior clinicians, whereas others developed the plans by working closely with each specialty in a true bottom-up approach through a series of facilitated workshops. This approach was highly recommended to others because it allowed realistic planning and engaged staff with the integration.

All the participants considered that ‘benefits realisation’ methodology⁵ was best practice for the planning and implementation of integration. None of the trusts reported accounting for the expected drop in productivity (caused by uncertainty) in their plans, and none were able to quantify what that drop was.

6.2. Integration planning: best practice review

The literature review found that integration planning should start early, during the due diligence process, to establish the best approach and identify the team that would take it to completion (Protiviti, 2014). One of the key reasons some integrations never happen is that the planning process was not resourced appropriately (Protiviti, 2014). Resources need to be put together for the planning before the integration process is determined (Davis, 2012).

The integration plan should clearly describe what decisions are required and what must be done and how on Day 1, in the first 100 days, the first year and beyond (Protiviti, 2014). A 100-day plan is usually the first to be created. This defines the integration plan at a high level, allowing early decision-making, and should include:

- development of a vision and strategy
- short- and long-term actions
- development of a cultural questionnaire and tool to measure culture gap and progress
- all project overviews, including initiatives for each function
- a cost–benefit case
- plans to ensure business as usual (Davis, 2012).

⁵ The benefits realisation methodology is defined by the Institute of Innovation and Improvement as “a tool to make sure you actually get the benefits originally planned for your project”. It involves defining, planning and structuring a change project around the desired benefits to ensure they are achieved.

The plan should be developed and built on to include short- and long-term plans (Davis, 2012). It should be clear how the integration will support delivery of all the aims of the transaction, not just the cost savings (Protiviti, 2014). Best practice recommends using a benefits realisation methodology (Davis, 2012; Galpin and Herndon, 2014).

The literature stresses the importance of involving operational staff from the start in development of the integration (Davis, 2012). It has the advantage of making sure the plans are realistic and also helps to engage staff with the change, which increases the chances of successful delivery. Plans should be reviewed and validated by key employees for each function.

It also recommends a review of the 'readiness to integrate' for each function to understand when different parts should be integrated (Davis, 2012). This helps staff understand where limited resources are best directed, where there is already ongoing change and where further information is required to make decisions.

There is evidence that during integration, employees lose focus on their daily tasks, which leads to a drop in productivity (Davis, 2012). This is an inevitable consequence of the uncertainty that employees face at a personal and organisational level, and which often results in loss of morale and organisational performance (Davis, 2012). This fall in productivity can be partly mitigated through good 'change management' practices. Extra capacity should be factored into the integration plans to ensure that the organisation continues to meet its performance targets during this period (Davis, 2012; Galpin and Herndon, 2014).

6.3. The degree of integration: interview findings

All the participants said their trusts aimed to fully integrate back-office functions but the level of integration planned for clinical services varied among specialties. All transactions reported that the actual level of integration achieved was much lower than expected in at least some clinical services (see section 8 'Execution of integration plans' for more detail).

Although some participants considered that their detailed integration plans were the foundation of their success, others reported that theirs were not detailed enough or did not correctly identify potential synergies.

One participant recommended:

“When you do synergy work, define in the first instance what it is that you can influence... There are some posts that you just need to have lots of. I wish we had done more work last year on what the really influential synergy piece was.”

Optimism bias⁶ was also reported as a reason for underachievement of synergies. Another participant said:

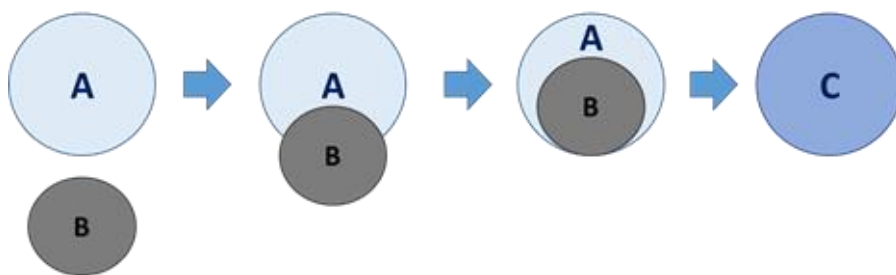
“When you’re looking at organisations in abstract, there’s a certain optimism bias as to how much you can take out... What you then find is that when you come to do it, you have to put some posts back in.”

One key challenge was a lack of understanding of how distance between sites would affect the potential for integration of clinical services. See section 8 ‘Execution of integration plans’ for more detail of this and other challenges.

6.4. The degree of integration: best practice review

The level of task and people integration depends on decisions relating to the level of integration for the acquired entity (see Figure 2), ie whether to treat it as a separate part of the organisation, absorb it fully, or aim for some level in between (Davis, 2012; Proft, 2014).

Figure 2: How far to integrate?



Source: Danny Davis (2012) ‘M&A Overview.’ In M&A Integration: How To Do It. Planning And Delivering M&A Integration For Business Success. John Wiley & Sons Ltd, UK: 3–15

Choosing the correct level of integration is crucial: an unrealistic level may mean the transaction has the potential to waste a lot of money and disrupt services without delivering any benefits. Davis (2012) recommends making clear in the integration plans the extent to which each function or service will be integrated. Resources will be limited, so balancing the available budget with potential synergies is crucial.

Due consideration must also be given to interdependencies and how integration of certain functions (or lack of it) will affect others (Protiviti, 2014). An obvious example of the cross-functional co-ordination required is information technology (IT) system integration, which has an impact on the level of integration that can be achieved in operational services. In this study, delays in the integration of electronic clinical

⁶ Optimism bias is the tendency for people to think that they are less at risk of negative events than their peers. In mergers and acquisitions it usually refers to being overly optimistic when projecting merger synergies and benefits.

records in one trust were reported to have slowed down the pace of clinical integration.

Recommendations

12. Assess the readiness and ease of integrating each function and clinical specialty.
13. Factor the likely post-deal dip in productivity into the integration plans.
14. Include clinical staff in integration planning to keep plans realistic and engage staff with the change.
15. Develop comprehensive integration plans detailing the level of integration for each function and specialty, such as IT.
16. Use a benefits realisation methodology to deliver post-merger integration.
17. Make sure plans detail how non-financial benefits will be realised.

7. Integration governance

The trusts surveyed reported managing integration governance in very similar ways, but resourcing delivery varied to a greater degree.

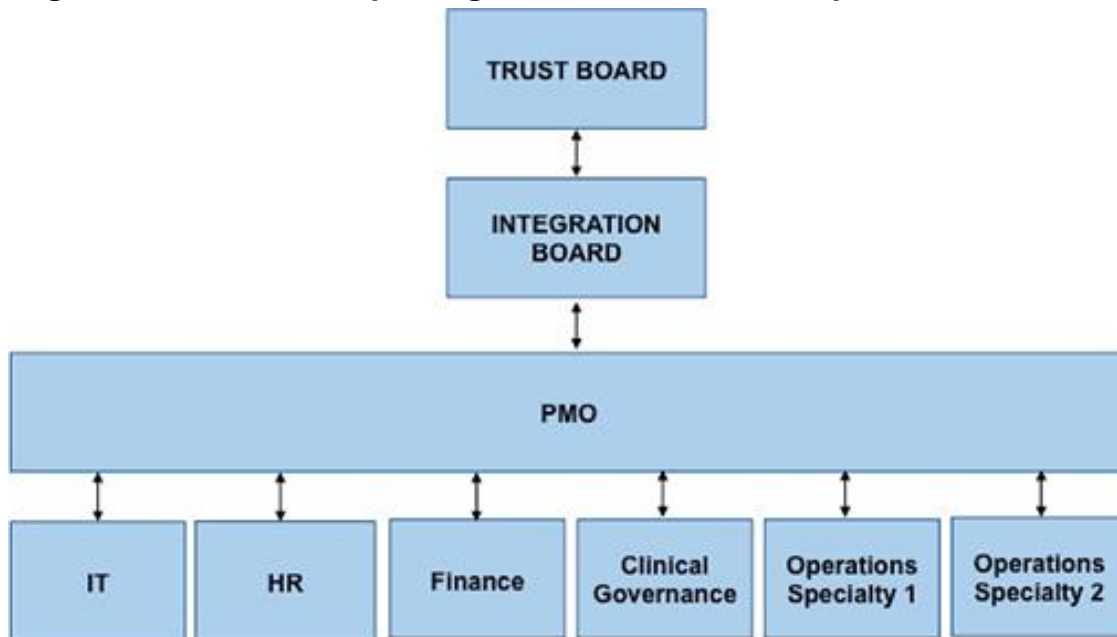
7.1. Governance structures: interview findings

All the trusts reported a governance set up similar to that in Figure 3 below, which includes:

- an integration board (or committee) led by an integration lead director and attended by the chief executive or chair among others; these boards reported progress to the trust board
- an integration balance scorecard or key performance indicators (KPIs) in the organisation's scorecard for reporting to the board
- a project management office (PMO), which reported back to the lead director and integration board
- project managers in the PMO working along a number of workstreams with operational leads in their specialties to deliver integration projects.

However, the way the PMO was resourced varied significantly. One trust set up two PMOs: one in both acquirer and target organisation; and both worked closely to deliver integration.

Figure 3: Generic example of governance structure reported



Trusts maintained the above governance set-up throughout integration.

One trust created 'home' and 'transaction' boards led by non-executive directors to reduce board meeting workload pre-deal and avoid losing focus on business as usual. Both were attended by the chief executive, chief finance officer and chief operating officer. The 'home' team reviewed performance and quality and safety in the 'home' organisation while the 'transaction' board planned and managed the transaction. These boards in turn reported into the trust board on an exception basis and were said to work very well in avoiding losing focus on business as usual.

7.2. Integration team and project management: interview findings

All the trusts surveyed reported very similar governance structures, although the resources allocated to integration varied. All the integration teams included:

- an integration programme lead
- a central PMO structure
- project managers working on several workstreams across the PMO and operations
- clinical managers delivering change within clinical operations.

Some trusts had extra resources such as clinical transformation leads supporting clinical integration.

7.3. External versus internal staffing: interview findings

Some organisations only used internal staff, particularly where there was already a competent PMO in the acquiring trust. Many interviewees preferred not to use interim staff, reserving them for a few posts for which it was the only option for bringing the necessary skills into the organisation, eg in IT.

Trusts that used internal people strongly recommended it to others. While all the trusts used consultancies to develop their integration plans, the level of involvement of these consultancies varied post acquisition. Interviewees described the following experiences of using external versus internal staff:

- Some trusts used management consultancies to manage the integration and reported that there was a void after the consultants left.
- One trust reported that the consultants left too soon after the transaction (three to four months) because they were too expensive to retain.
- The trusts that used mostly internal people reported much better continuity in implementing plans; however, some respondents reported that their trusts did not have internal people with the correct skills
- Some trusts reported providing specific training for those involved in the integration but other trusts did not.
- One trust brought in some experienced interim staff to deliver defined projects but found this did not work well due to the high level of interdependence of integration projects. They decided a team-based approach was preferable.
- All of the respondents used internal staff for operational delivery since clinical managers needed to own the integration projects; all respondents recommended doing it this way, but many did not backfill operational staff or did so only partially.

The lack of skilled managers in the NHS was mentioned as a key challenge in finding enough capacity to deliver change. Respondents had concerns about moving skilled internal managers into the integration team as their posts would have to be backfilled by potentially less experienced or interim staff who did not know the organisation.

Most trusts felt that their integration teams were under-resourced and in hindsight would have increased capacity.

Furthermore, many respondents reported that business as usual took over and momentum for integration was lost – sooner for some than others. This made the last few changes hard to deliver. However, none of the respondents linked the loss of momentum with a capacity issue.

One trust, however, reported doing things differently. They used senior managers from the acquired trust to provide the extra management capacity needed to deliver the integration over a two-year period, after which they were supported to leave the organisation and find other roles. The organisation benefited from very low redundancy costs and the organisational memory those individuals brought to the integration process.

“You didn’t end up with resentment permeating through the organisation... People felt they had meaningful work to do, they contributed to it and it added to their CV... Looking at skills that individuals had and then working with them...provided them with coaching... I said we can’t afford to lose the intelligence... We had a vision, we didn’t get rid of anybody because there was a lot of work to do but we had a plan that those people would exit as we went through.”

The same trust reported working in a partnership model with a management consultancy resulting in much more knowledge transfer than the traditional consulting model during both planning and integration.

“...created an office space where they [the consultants] came and they based themselves in the week along with [my] improvement team...and they had shared experiences. That meant less resistance from some of our clinicians when they were working on the integration plans in their specialties. They saw them working alongside us...so when they exited it was smooth. There wasn’t this sudden drop and we were then able to continue monitoring that integration progress.”

Respondents from this trust reported that it worked very well since it allowed the trust to draw on the consultancy for expertise while delivering better continuity.

7.4. Best practice review

The research unanimously recommends that the integration is led by a single executive integration lead manager with the ability to take the necessary decisions. It should also be overseen by an integration committee, including senior executives, which monitors the achievement of synergies against the plan (Protiviti, 2014). A senior officer for each function and business unit involved in the acquisition should be part of this committee, supported by other key leaders as required. Committee members should provide a strategic steer and take key decisions around budgeting, dependencies, timing and priority in their respective areas (Galpin and Herndon, 2014).

The literature also recommends regular review of projects. Things change very quickly as new information about the target is uncovered so it is important to identify projects that are not working early and reallocate resources (Davis, 2012).

Protiviti (2014), Davis (2012) and Galpin and Herndon, (2000) recommend a team structure that includes:

- a central PMO
- multiple functional teams including: IT, HR, finance, sales, customer service and the operations and supply chain.

You could have sub-teams in each function if the workload requires them, although the authors recommend not having too many to avoid dilution. The literature recommends that a PMO should include some members of the due diligence team as well as programme and project managers. The functional teams, on the other hand, should be internal employees working with the PMO through a dedicated liaison person (Protiviti, 2014). While PMOs can be supplemented with external consultants, functional teams need to be internal, may require training and their posts should be backfilled (Davis, 2012; Protiviti, 2014).

Davis (2012) also recommends that external consultants who have integration experience but do not understand the organisation should work closely with internal staff. It is important to bring in expertise but care must be taken to avoid poor continuity and loss of momentum when their work is completed. The partnership model described for one of the trusts in Section 7.3 is a good example of how these recommendations can be implemented.

The models reported by trusts were very similar to those recommended in the literature, but there were not sufficient resources in some of the transactions.

Recommendations

18. Use internal staff where possible but bring in external mergers and acquisitions expertise if it is missing.
19. Ensure that some of the people who develop the integration plan also implement it.
20. Backfill internal staff delivering the integration plans to maintain business as usual during integration.

8. Execution of integration plans

8.1. Execution of integration plans: interview findings

Interviewees stated that not all trusts delivered integration according to plan. Different functions and operations had distinctly different levels of achievement and ease of delivery.

Most trusts reported successful delivery of their back-office integration. Projects were delivered more or less on time, achieving savings mostly in staff pay costs through merging and co-locating teams.

In contrast, respondents unanimously reported that clinical synergies were much harder to achieve than anticipated. In many cases, they felt that integration plans had underestimated how costly and difficult this would be. Trusts that reported being more or less on track with their clinical integration plans still delivered their integration at different speeds than they had expected.

One respondent reported:

“There was a plan directorate by directorate... organised by the medical directors...[which] has had to be flexed a little bit because we realised there was the opportunity to do more integration and quicker than the plan said...but in other directorates it had to take longer. It was pretty detailed and quite well done.”

Few initiatives were delivered ahead of plan; most reported delays. Others did not happen at all. The challenges identified in rough order of magnitude were:

- **loss of momentum and business as usual taking over** after the initial redesign; many interviewees reported they felt they did not push for synergies “hard enough [and] early enough”
- **the plans underestimated the amount of effort** that would be required to change clinical services
- services on **different sites were harder to integrate** than predicted
- specific projects in the clinical integration plan were **opposed by key external stakeholders**, eg CCGs or Healthwatch
- limitations to clinical services integration due to the **local relationships required for some services**, eg with local authorities, social care and community services
- requests from regulators, eg the consequences of CQC inspections were that synergies became a secondary priority and limited resources were partly redirected.

Participants attributed the difficulties in delivering clinical synergies to two main ‘people’ issues:

- **poor engagement of clinical leaders** in some clinical specialties
- **staff who resisted change.**

A number of themes emerged when respondents were asked what they would change in hindsight.

- Some considered that **detailed synergy plans** were key to success, while others wished their institution's plans had been more detailed, particularly on the level of clinical integration (and synergies) in specific specialties.
- The **distance between the acquiring hospital and the acquired site(s)** emerged as a very important consideration in understanding the level of clinical integration that can be achieved across locations for each specialty. Respondents reported that while it is possible to integrate services across trusts within a few miles of each other, this becomes increasingly difficult with increasing distance.
- Two trusts reported that **centralisation of services** was a good way to achieve clinical (operational) synergies, particularly with elective services. However, other respondents who failed to centralise services recommended giving due consideration to all the stakeholders when planning as they may oppose plans. These issues were reported to be more likely with non-elective services.
- In hindsight, most trusts reported **underestimating the amount of effort** and investment required to turn round a failing organisation. On top of underestimating the effort needed to change clinical practices, respondents also commented that clinically excellent trusts found acquiring a failing trust difficult because they were not accustomed to the kind of culture and regulatory pressures that failing trusts are subjected to. Unlike well-managed trusts, failing trusts were also reported to lack performance data.
- **Commissioning intentions** were a barrier, in spite of commissioners being in agreement with service integration plans prior to transaction. Priorities and commissioning bodies changed so quickly that one trust reported that commissioner support for its integration plans was lost by the time they were ready for implementation. Most respondents reported that the fragmentation of the commissioning system was a barrier to standardisation because of diverging demands.
- Most respondents reported that in hindsight they would have **delivered integration faster** to maintain momentum and seize the opportunity for making changes before the priorities of business as usual took over.

Therefore the key challenges reported were partly related to insufficiently realistic (ie too optimistic) integration planning and partly because of the nature of the public healthcare environment in the UK.

8.2. Best practice review

In a study by Miles et al (2014), synergy overestimation was the second most important cause of poor deal outcomes. They attributed this overestimation to a need to justify the acquisition price and a lack of understanding of the realistic level of synergies that can be expected. Their study shows that companies which over-delivered their synergies only did so because they had come to understand their synergy potential through benchmarking and due diligence, and deliberately used the merger to deliver cost benefits beyond economies of scale. These companies used mergers as opportunities to introduce methods such as zero-based budgeting and new ways of working to reduce costs.

McLetchie and West (2010) showed that organisations that over-performed on their synergies maintained flexibility, which enabled them to identify and capture additional value. Merging operations delivers a conservative amount of synergies while transformational activities can increase value creation by dealing with long-standing business constraints. Therefore this extra value is created by taking advantage of the 'unfreezing' of the organisation and focusing on a few key processes, functions or business units that have high transformative (financial) synergy potential. The findings in this study were very similar to those reported by EY (2013), in which executives reported that in hindsight they would have allocated a higher budget, increased integration resources and integrated faster.

The literature emphasises the need for speedy integration. Speed affects the financial targets through an early reduction in (recurrent) business costs through synergies (Angwin, 2004; Davis, 2012). It also shortens the period of uncertainty for employees resulting in reduced productivity losses and uses the momentum in the early days post deal more fully (Angwin, 2004; Bauer and Matzler, 2014; Galpin and Herndon, 2014).

Some consultancies even advocate delivering full integration within the first 100 days (Angwin, 2004; Davis, 2012; Bauer and Matzler, 2014; Galpin and Herndon, 2014). Others, like KPMG (2011), define 'fast' merger timelines as less than two years. Others still, consider seven months to be short and two years to be long. This inconsistency in the definition of fast and slow integration in the literature makes it difficult to make specific recommendations. Moreover, Bauer and Matzler (2014) warn that although it is common practice to recommend fast integration, there is no strong evidence to support this statement. It has also been postulated that a slower integration may reduce conflict, improve trust-building and reduce disruption of the business.

Some organisations integrate over two phases; with the second phase delivered after review of the first and benefiting from better knowledge of the acquired organisation. In reality, different functions integrate to different levels and at different

speeds (Davis, 2012). A balance that suits the specific transaction and function must be found.

Bauer and Matzler (2014) recommend that the choice of speed of integration should not automatically default to 'fast' but be tailored to the transaction. Implementing change in public services is known to be complex and may also take longer because of the many stakeholders (Grant Thornton 2010).

8.3. 'Day 1': interview findings

All the trusts reported that management of Day 1 activities was very successful: they had clear plans for Day 1 integration, made sure that services were not disrupted and staff felt they were part of a new organisation.

Many reported organising activities to welcome new employees, such as:

- **visit from the executive team** and open meetings with all staff at the new organisation
- **a welcome pack, booklet or trust merchandise** for staff
- overnight change of signage to ensure that branding felt different; in some cases including name badges and/or uniforms to help staff identify with the new organisation
- making sure **staff knew what to do** and who to contact if issues arose – to stick to their 'old' policies and make sure they knew who they were reporting to – which was achieved through a number of communication channels.

From a change management perspective, it was seen as very important that the visual signs of the merged trust were visible on Day 1 (Herndon, 2014).

Respondents emphasised that good communication was invaluable during the entire merger process.

One chief executive reported that the best advice that they received was from a non-executive director, who had private-sector merger and acquisition experience. He recommended "...scale back your ambition and...have a safe landing".

All the executive teams interviewed saw a 'safe landing' as a priority. Leaders ensured that all staff knew who to report to and how to escalate issues. They also organised a proper welcome for new members of the organisation.

Key activities delivered on or around Day –1 included the integration of the telephone system, computer log-ins, email and intranet(s).

Participants reported that in most of the transactions the restructuring of management and back-office functions was planned before Day 1. This ensured that back-office functions for the new organisations were integrated and synergies were

secured early on. They pointed out that the workload for corporate services, particularly HR, IT and finance, actually increased for some time during the integration so early integration of the back-office helped because staff were in place to support clinical operations through the integration.

Some trusts also merged other IT functions such as payroll, finance and HR around this time but respondents felt that whether these were integrated on Day 1 or ran in parallel for some time did not materially impact the outcome.

8.4. Best practice review

Herndon (2014) reported that poor delivery of Day 1 activities is a strong indicator of mergers and acquisitions failure. A 'safe landing' on the first day suggests that the leadership team knows what it is doing and promotes employee confidence in its ability to take the organisation through the integration (Protiviti, 2014). As PwC (2013) points out, "you only get one chance to make a first impression".

Day 1 initiatives are specific to each transaction but most organisations will deliver the key changes outlined below:

- Consistent communication of messages (including speeches by the chief executive) using appropriate branding for the new organisation and making time to answer employees' questions. Davis (2012) recommends ensuring that employees hear the messages from the leadership team first, before other sources where possible.
- IT integration, which is also central to HR, finance, procurement and communications (email, intranet, etc). Best practice recommends making arrangements to ensure continuity of service, maintaining service volume and quality for customers (Davis, 2012).

Figure 4: Key Day 1 activities



Sources: Protiviti, 2014; Galpin and Herndon, 2014

Recommendations

21. Do not underestimate the difficulties of implementing change due to the human factors of change management.
22. Consider the distance between sites when deciding on the levels of integration among specialties at different sites.
23. Get a grip on the target as quickly as possible and maintain the momentum of integration, ensuring all necessary approvals have been obtained.
24. Consult and get in writing the agreement of stakeholders to integration plans. Do not make assumptions about the standardisation of care when other stakeholders' approval is required for implementation.
25. Develop and implement a strong Day 1 plan to enhance staff confidence in the new leadership and cultural integration.

9. Realising the benefits

In most cases the key rationale for the acquisition was improving clinical safety and the quality of services in a failing trust to guarantee continuity of services. However, according to interviewees, clinical integration was not fully delivered in most of the transactions.

9.1. Interview findings

Clinical benefits

Some improvement in clinical quality was achieved in all the transactions, although performance in relation to national outcomes was still poor for some at the time of interview. Participants indicated that these would require more time to improve.

Respondents considered that the 'performance holidays' allowed by the regulators were too short. They reported that it took between 12 and 24 months to turn round a failing trust. Intervention from the regulators at early stages sometimes distracted trusts from delivering their integration plans because they shifted their focus and resources away from integration. Moreover commissioners often did not abide by these 'performance holidays'.

Some interviewees pointed out that performance of outcome measures in the target organisation were better than those in the acquirer at the time of interview. They attributed this to the dilution of attention on business as usual in the acquiring organisation caused by the acquisition.

Financial benefits

Some trusts reported going into financial deficit after the acquisition in spite of the transaction funding. Respondents suggested this was mainly because of surprises that emerged post takeover, such as:

- unequal pay banding across sites, resulting in extra cost to implement equity in pay banding; the failing trusts were sometimes understaffed or using lower banded staff to deliver the same services
- high vacancy levels requiring agency nursing to ensure minimum safe levels of staffing
- estates costs because of compliance and maintenance issues missed by due diligence
- inability to deliver economies of scale in clinical services.

Although financial benefits were clearly projected and articulated in the business cases, respondents reported that the projections did not work out due to (in order of importance):

- being based on over-optimistic clinical synergies
- underestimation of the effort required to deliver change and therefore, the investment required
- changes in NHS policy which increased costs (most mentioned the Francis report and resultant minimum staffing levels for nurses, although this was not related to the mergers).

One respondent reported:

“We focused very well on the integration from a clinical point of view and the standards improved a lot at [hospital name]... Still not in some areas where they need to be, but they certainly improved a lot from where they were...and the patient experience has improved a lot... but on the operational side of the integration, we probably did not work...hard enough and fast enough partly because we tried to spread our own resources too thinly... We didn’t plan to spend that much and we didn’t spend that much. We probably didn’t spend enough again compared to a private-sector transaction.”

One respondent also pointed out that while private deals could draw on both cost and revenue synergies, NHS deals frequently had just one lever to pull so if the merger did not achieve cost reduction, it failed from a financial viewpoint. ‘Repatriation of referrals’⁷ was one of the few revenue synergies claimed in some transactions. Whenever repatriation of referrals was in the integration plan, it was delivered and in one trust was even over-achieved.

Many participants reported that the acquisitions were only partly to blame for the trusts’ poor financial performance and that the tough financial NHS environment over recent years had compounded their financial problems.

Could the benefits have been delivered without an acquisition?

Many of the respondents reported that the benefits achieved would not have been possible without the acquisition. They reported that the main problem with the failing trusts was inadequate leadership teams and while, in theory, this could be improved through a management contract, in practice it was very difficult. In an acquisition a well-functioning stable leadership team was brought into the organisation.

Some of the respondents reported that working in partnership could deliver many of the benefits related to service improvement and redesign, such as the rationalisation

⁷ ‘Repatriation of referrals’ refers to referrals (and therefore clinical activity) for a specific service coming back to a trust after they had been lost to other trusts because for example a service was stopped locally.

of clinical services to one site and consolidation of back-office teams, but not cost reductions due to a decrease in top management costs.

9.2. Best practice review

Potential benefits from healthcare mergers fit into four categories (see Figure 5).

Figure 5: Four categories of merger benefits in healthcare



Source: Adapted from Cereste et al, 2003

In the private sector, acquiring organisations derive financial benefits from both revenue and cost synergies (Davis, 2012; Galpin and Herndon, 2014). In the not-for-profit sector, however, organisations have less access to revenue synergies and therefore may be less likely to deliver financial benefits (La Piana and Hayes, 2005). In the NHS, hospitals do not have control over prices so revenue synergies can only be driven by volume through, for example, an increase in referrals or bed occupancy rates. Margins can only be manipulated by decreasing costs. This makes accurate projection of cost synergies crucial as financial benefits from the deals hinge on them.

Clinical benefits are also often stated as key drivers for hospital mergers but there is no definite evidence that mergers alone necessarily deliver clinical benefits (The King's Fund, 2014). Some argue that they cause a deterioration in clinical quality (Ho and Hamilton, 2000). Outcomes for not-for-profit mergers may need to be considered in comparison to the projected outcomes without the merger, rather than focusing just on improvement (La Piana and Hayes, 2005). In some cases the desired benefit is to avoid further deterioration.

Evidence from healthcare mergers in the US and UK finds that most mergers have not delivered the planned benefits (Cereste et al, 2003). The recent Dalton Review recommends considering alternatives to hospital mergers to deliver the desired benefits like joint ventures and management contracts (Dalton, 2014).

The question is whether it is worth putting NHS organisations through the pain of a merger when other options may be just as successful (Cereste et al, 2003). At present, the literature is unable to provide the answers (Ho and Hamilton, 2000; Cereste et al, 2003; Protopsaltis et al, 2003; The King's Fund, 2014).

Recommendations

26. Be realistic (conservative) when planning synergies, particularly clinical synergies.
27. Create dedicated teams focused on realising all benefits and rigorously performance manage these teams.
28. Understand and include the cost of aligning pay and staffing levels across the two organisations in the transaction costs.
29. Negotiate a realistic performance holiday of at least 12 months from both regulators and commissioners.

10. Leadership

Interviewees made several recommendations related to organisational leadership.

10.1. Executive team: interview findings

According to participants, the executive teams of the acquiring trusts were all fully involved with the acquisition and the vast majority of the boards at the target organisations were removed completely. All the respondents said that the workload of the executive directors was very heavy during the merger process and they believed this was inevitable because decisions had to be taken by key people. However, many respondents recognised that below executive level the leadership did not have the capacity to deliver change and, in retrospect, would have ensured that they had enough capacity.

Most executive participants surveyed had little or no mergers and acquisitions experience and were aware of this, bringing in external consultancies to provide expertise. Many non-executive board members however did have (private-sector) mergers and acquisitions experience, which executives reported finding very useful. Consultants also offered useful challenges and questions.

Some executives also sought advice from other NHS trusts that had been through the process but some of these declined to share information due to commercial sensitivities. Respondents highly recommended sharing acquisition experience across the NHS. Those who did receive advice found it extremely valuable.

10.2. Executive team: best practice review

In the literature on private-sector mergers and acquisitions deals, the level of involvement of the board tends to depend on the size of the acquisition relative to the organisation and the risks the transaction creates for the organisation as a whole (Protiviti, 2014). The role of board members has been described as:

- overseeing strategy
- monitoring organisational performance
- overseeing risk management
- advising management.

In the NHS transactions reviewed, the board was highly involved with the transactions, with some chief executives even taking on the role of lead director for integration. This was probably because of the large size of the transactions relative to the acquiring trusts and the high level of integration intended (Protiviti, 2014).

Experience of mergers and acquisitions has been associated with positive outcomes (Bauer and Matzler, 2014). It is relatively uncommon among NHS executives compared to those in the private sector because of the relative infrequency of deals so it is often accessed via management consultants and/or non-executive directors. Private-sector experience is very useful, although there are differences between private- and public-sector deals, particularly around strategic rationale, negotiation and the benefits sought (La Piana and Hayes, 2005).

10.3. Management restructuring: interview findings

In most transactions, restructuring of the more senior management roles was reported to have started during the pre-deal period, so that the new management structure was in place on Day 1. All trusts delivered their consultation and interviews before Day 1 and many implemented these structures on the first day.

In most of the mergers reviewed, the tiers of management up to two levels below executive levels were restructured during this time. In others, all the management tiers were restructured, except for the clinical team lead tier, to avoid too much disruption on the first day. This was reported to have worked well.

Some trusts retained board members from the target organisation post acquisition. There was mixed feedback from respondents about how this worked. Some felt that it had slowed down the speed of integration because of guarding 'sensitivities' during board meetings but others felt that it was positive as they knew the acquired organisation well.

All the trusts felt it was desirable to have a mix of managers from both organisations in the new structure (below board level). However, in many cases, managers in the target organisation either left the organisation or lacked the required skills.

In the transactions surveyed, all management roles were included in restructuring, and management staff were interviewed in a fair and transparent manner. Many reported increased costs because of unequal levels of pay and staffing between the two organisations, which should have been picked up during the due diligence phase. In some cases, the choice of staff to leave the organisation was partly based on the associated redundancy costs. Early retirement was also encouraged.

The trust mentioned in Section 7.3 that used managers from the target organisation to deliver integration reported very positive results, particularly in retaining goodwill and sustaining the morale of staff staying at the organisation. However, it was recognised that this may not be possible in transactions where too many roles become redundant after re-organisation.

10.4. Management restructuring: best practice review

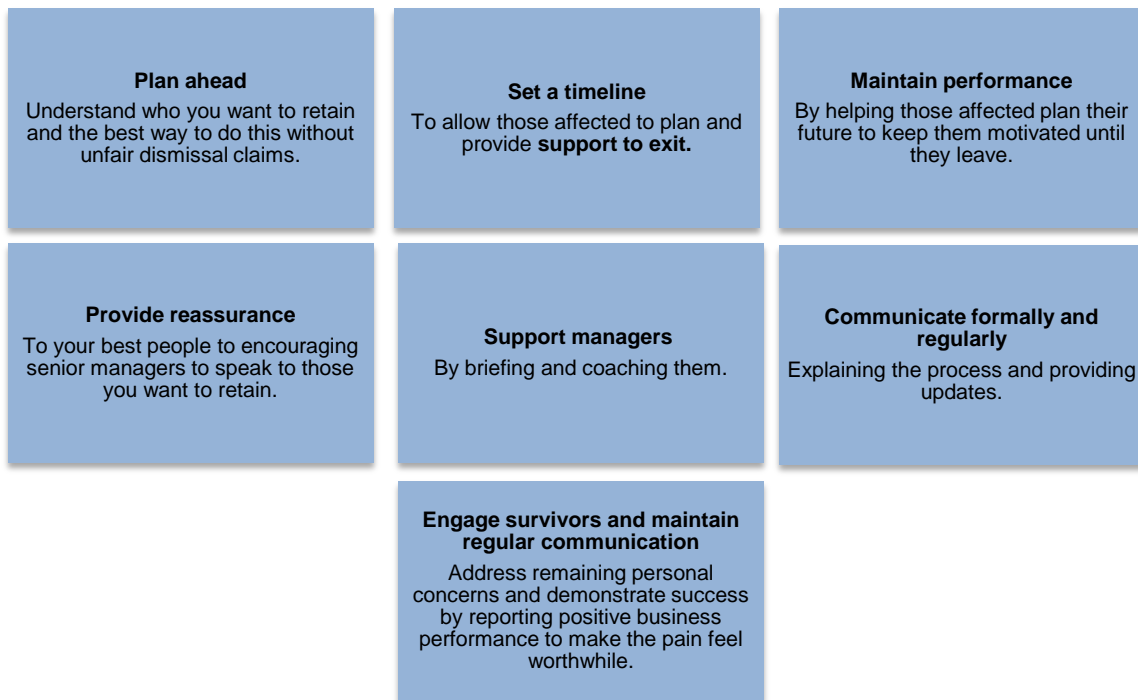
Best practice recommends that when restructuring following a merger, organisations should understand which key employees they need to retain (Davis, 2012; Galpin and Herndon, 2014) while Walsh (1988) warns that a high turnover of management in the target organisation is to be expected after an acquisition.

Moeller and Brady (2014) found that companies that were able to retain a higher percentage (63% vs 46%) of key employees from the acquired organisation improved their merger success rates. Galpin and Herndon (2014) recommend putting in place succession plans for key senior manager roles when restructuring following a merger.

When an organisation is going through restructuring, employees can be deeply affected on a personal level. Managers are often not skilled enough to manage the behavioural aspects and this can leave both managers and other employees feeling disengaged (Doerge and Hagenow, 1995).

The Chartered Institute of Personnel and Development (CIPD) provides the following advice on how to manage the inevitable human aspects of restructuring (Wood, 2008). See Figure 6 below.

Figure 6: How to manage the human aspects of restructuring



Source: Adapted from Wood (2008)

Another key aspect that has been linked to mergers and acquisitions failure is a mismatch in compensation and benefits between the two organisations. It is often missed at the planning phase and may result in a significant increase in merger costs. Discrepancies in pay and staffing levels are common and should be understood at the due diligence phase to inform pricing (or transaction funding in the NHS).

10.5. Organisational structure: interview findings

At all the trusts surveyed, interviewees felt that they did not get the organisational structure correct the first time round. The challenge of moving from a single site to a multi-site organisation was considerable for most and required a different way of working for the leadership and senior management teams.

In hindsight, there was unanimous agreement that the best organisational structure for a multi-site organisation was neither site-based management nor cross-site management along clinical specialties. Instead, a matrix model including a degree of both was recommended:

“[We] moved from a single site to a multi-site [organisation]... It presents enormous challenges. When you run a single site hospital you have plan A and plan B... You want to leverage the financial and clinical synergies...but manage the site on a day-to-day basis. There is no single way... You are always going to have to manage that balance between sites and services.”

Most trusts tweaked their structures as they integrated to move towards the best balance between site-based and cross-site management. In all cases, clinical specialties were managed across sites, which was particularly successful when done by highly regarded clinical leaders.

The dominant factor in deciding the balance between cross-site and site-based management in the matrix was the distance between sites. For hospitals within a maximum of one hour 'easy' travel from each other, a predominantly cross-site specialty-based management model was preferred, with a smaller degree of site-based management. Where distances were larger, a more site-based model was preferred to ensure enough operational capacity at all sites.

One trust, where the distance between hospitals was very large, implemented site-specific 'board' meetings attended by site managers and some executive board members. This model is more like the structure of a group (of companies) than a multi-site organisation and respondents indicated that it may hinder clinical standardisation unless information is codified appropriately.

None of the trusts felt that they had found the correct balance between site-based and cross-site management yet, so the best structure is still to be determined.

10.6. Organisational structure: best practice review

Following a merger, a key challenge is to design a suitable management structure for the new organisation. The organisational structure may be functional, product or geography based. In acquisitions the chosen structure will depend on:

- the structure and processes of the acquired organisation
- the degree of integration desired
- the relative size of the acquired organisation.
- the number of external stakeholders and relationships
- the level of autonomy devolved to management (this will both influence and be influenced by the organisational structure) (Lega and DePietro, 2005; Connor et al 2012; Davis, 2012).

All NHS foundation trusts show a function-based organisational structure centred on discipline-based specialties or directorates like, for example, surgical and medical directorates (Lega and DePietro, 2005; Connor et al, 2012; NHS Trust Directory, 2015). This structure predominates in hospitals in industrialised countries; it works best when business units are self-contained and autonomous but may result in 'silo' working (Connor et al, 2012).

The choice of management structure varies on a continuum from site-based to centralised cross-site management but the correct balance will be different for each

organisation. While the literature shows that there is a link between decentralised decision-making (autonomous managers) and clinical quality, the research relating to organisational structure is limited (West, 2001; McKinsey, 2010; Department of Health, 2014; Kinston, 1983; McKinsey & Co 2011).

Recommendations

30. Tap into the mergers and acquisitions experience brought by non-executive board members.
31. Seek peer support from executives in other NHS trusts who have recent mergers and acquisitions experience.
32. Ensure that the integration team and operational integration leads are adequately resourced to deliver integration, while also ensuring a strong continuing focus on business as usual.
33. Consider distance between sites when planning the new organisational structure:
 - if there is not an easy commute (up to one hour between sites), consider site-based operational management, devolving powers to site managing directors. In this model, codify information to maximise clinical synergies
 - if there is an easy commute, consider creating a more cross-site organisational structure, joining up services along clinical specialties.

11. Culture

11.1. Interview findings

Although most trusts reported giving culture at least some consideration, many did not have a comprehensive plan of how to manage it and did not try to understand cultural fit. Most trusts carried out cultural due diligence, but it ranged from using cultural surveys (to measure staff satisfaction) to a detailed analysis of values and concerns.

One respondent reported some of the questions they used:

“We asked, ‘What are the things that you want to keep? What are the things you believe are good? What do you feel would be a loss?’”

All the acquiring trusts reported developing and/or extending their organisational values to the acquired organisation. However, while all of the respondents reported trying to understand the culture, not all of them tried actively to influence it. The vast majority of respondents recognised cultural differences as a key challenge post-merger and felt that culture should have been managed better.

There were two main attitudes towards cultural management:

- Management deemed that the culture (or rather many cultures) within a healthcare organisation could not really be influenced very much but they actively measured staff satisfaction and communicated effectively with staff to ensure that values relating to patient safety and service excellence were ingrained (see the first four subpoints below). These organisations felt they had managed culture well, but some felt more work was needed.
- Management created a more comprehensive plan to manage culture, including not just values but also identifying behaviours that the trust wanted to promote and a programme of cultural management. Most trusts reported putting in place a few of these and one trust developed a very comprehensive model methodology, including all the following:
 - **cultural due diligence:** one-to-one and group interviews with staff and online surveys used to understand the culture; grievances, HR reports and absences also reviewed and all the information synthesised pre-integration to create a new set of values based on those of the acquiring organisation but developed with staff from both
 - **ongoing measurement:** surveys at intervals to measure and understand progress against values and behaviours
 - **training:** trained hundreds of managers on the trust's values and behaviours, and how these would be included in trust processes
 - **communications:** electronic communications, roadshows and workshops with staff
 - **rewards:** rewarded correct behaviour by including value framework standards in performance appraisals for all staff
 - **hiring and firing:** based hiring and interview and disciplinary processes on organisational values
 - **induction:** rewrote the trust induction in line with new values
 - **teams:** trained coaches in team-based learning to implement the training across the organisation
 - **listening:** created a 'listening' programme

- **awards:** created staff awards explicitly rewarding desired behaviour.

This methodology was reported to be successful and the trust's staff survey results showed that staff identified more with trust values and staff satisfaction scores increased.

Where the transaction was an acquisition all the respondents reported calling it a merger initially, with most reporting this was the wrong approach. Respondents felt that it was clear that the transaction was an acquisition because the board of the target was removed and there should be transparency from the start, so that staff did not feel misled. Most executives felt that making it clear that the start that the transaction was an acquisition would have made things easier.

Those who called the transaction a merger reported that staff still felt as if they had been taken over. Some felt that calling it an acquisition would actually be positive, particularly if an organisation needed to be directive to improve care in the target organisation. Respondents who called it an acquisition reported mitigating the feeling of being taken over by communicating frequently with staff and making sure that when they adopted clinical processes and good practice from the target organisation they communicated it widely to show that the staff of the target were being treated as equals.

Respondents recognised, however, that it was inevitable that staff would have to go through psychological acceptance of the change, which takes time and investment.

11.2. Best practice review

Cultural clash and employee resistance can make the integration phase very risky. Good cultural fit has been associated with lower resistance to post-merger integration, while a poor fit was shown to mean that changes take longer while employees become more familiar with the new culture and accepted it (Bauer and Matzler, 2014). From an anthropological point of view, the imposition of a dominant culture causes high levels of conflict (Berry, 1983).

Cultural clash can appear in a number of ways as outlined below, increasing in intensity from one to four (Marks and Mirvis, 2011):

1. Perceived differences: people focus on differences.
2. Magnify differences: distinctions become larger and diverge more widely.
3. Stereotypes: typecasting others to embody the 'other' culture.
4. Put-downs: the 'us' and 'them' situation where cultural clash has reached full height.

While some of the literature states that clash of cultures is a major cause of failure to achieve the objectives of a mergers and acquisition transaction, others claim that

differences in business practices can enhance post-merger performance (Marks and Mirvis, 2011). What is certain, is that there is a clear relationship between managing culture actively during the mergers and acquisitions process and achieving the desired outcomes (Schweiger and Goulet, 2005).

Models of cultural management

There are several models of cultural management, many based on the Schein cultural model (Protiviti, 2014; Schein, 1984). Marks and Mirvis (2011) describe a framework that can help executives manage culture in merger and acquisitions transactions. They recommend ensuring that HR plays a key role in the process from due diligence through to integration:

The organisation first needs to decide on the cultural end-state towards which it wishes to work. These decisions will depend on the level of integration desired for each function or department, and will pivot on the business case. The cultural end-state is also realistically expected to change during the process and is a journey.

As with some of the trusts involved in this study, the authors recommend identifying the values and practices which the organisations are most proud of to take forward to the new organisation.

However, this is not enough. Managers must exhibit the desired behaviours and the organisation must consistently promote them through its processes and policies, as well as actively engaging staff with the process. The culture management methodology in Section 11.1 is a very successful example of this.

Levels of culture

The literature identifies three different levels of culture: organisational, national and occupational cultures. While the first two feed the cultural clash after a merger, occupational culture can improve cultural integration (Viegas-Pires, 2013; Glomseth et al, 2007). Occupational culture is “a reduced, selective, and task-based version of organisational culture that is shaped by the socially relevant worlds of the occupation”. This sub-culture may be particularly relevant to healthcare mergers in which clinicians are likely to co-operate and co-ordinate services better as a result of similar occupational cultural norms within specialties.

Managing culture using the correct tools is key to integration success. ‘Shallow’ culture management is associated with increased culture clash (Schweiger and Goulet, 2005). On the other hand, ‘deep’ cultural management, including dialogue and cultural learning and clarification workshops at which staff can discuss culture openly, increases integration success. These improve outcomes through the smoother resolution of cultural differences and increased co-operation between employees and commitment to the merged organisation.

Terminology

The relevance of merger terminology, ie calling the transaction a ‘merger’ rather than an ‘acquisition’, has not been studied in mergers and acquisitions literature, but practitioners seemed to agree to be that ‘merger’ is often used to make the deal sound co-operative. Culture clash led to feelings of takeover regardless of the nature of the transaction (Marks and Mirvis, 2011) but one of the key determinants of successful cultural integration is employee ‘trust’, which may be compromised if the transaction is depicted as a merger which then turns out to have been an acquisition.

Recommendations

34. Do not underestimate the challenges of cultural integration. Develop and carry out a consistent and comprehensive culture programme.
35. Ensure that the culture programme is ‘deep’ and includes cultural learning and clarification workshops.
36. Carry out cultural due diligence to understand differences in culture:
 - Identify the desired cultural end-state and manage culture actively to achieve it.
 - Provide the opportunity for clinicians to work with their colleagues within specialties across sites.
37. Be honest from the start if it is an acquisition and not a merger of equals.

12. Regulators and commissioners

12.1. interview findings

The findings frequently highlighted challenges that are caused or exacerbated by the regulatory process. Below is a list summarising these findings and key recommendations. Although trust leaders may not be able to influence all of these, regulatory (and commissioning) bodies may wish to consider these recommendations in future developments.

- The **fragmentation of the commissioning system** makes standardisation of services very difficult due to CCGs wishing to commission different services in different patches covered by the trust. Some respondents suggested that NHS England or other regulators may be able to work with commissioners to agree common service development plans.
- The **‘performance holiday’ given to providers is too short** and both CQC and Monitor were reported to step in too early at times. Commissioners were also said to step in too early to impose contractual outcomes, and at times

finances, which further worsened the trusts' financial positions. Service improvement takes time and dealing with regulator requests can reduce focus and redirect resources away from the integration too early. Respondents believed regulators should expect a minimum of 12 to 18 months before any performance improvements are observed.

- The pre-deal period was considered to be too long (15 to 24 months). A reduction would reduce the period of uncertainty for trusts and avoid increasing costs. Some respondents recommended **that the approvals process should be streamlined so that the pre-deal process takes 9 to 12 months**. This process was also seen as fragmented and could be improved by better co-ordination (eg of CCGs) and allowing parts of the system to be reassured by other bodies to avoid duplication and work for trust boards.

Overall the trusts' experience with the regulatory process was not very positive. Although all the trusts reported that Monitor was very supportive during the transaction and provided the correct level of challenge to trusts, many felt that the overall system was not supportive enough and did not allow trusts enough time to improve performance.

“[Before], we were dealing with Monitor, now we're dealing with Monitor, NHSE, TDA, CCGs and they don't all sing from the same song sheet... It's made it much more difficult for us.”

Some respondents even reported that they would not recommend others to acquire a failing trust because the regulators do not acknowledge that it may take up to two or three years to turn it round.

“We found there was an issue post-acquisition...of a contractual nature... We were not given any time or space to sort things out... [Hospital name] was a failing organisation for quite some time and you don't sort that out in 6 to 12 months. It takes much longer, but the system doesn't give you the space and time to do it. The system has a very short memory. So, despite having a transaction agreement that is meant to be non-penalising ...we are in a punitive, penalising relationship with the CCG.”

Moreover, they reported that the inherent risk (and limited options) within the system meant that many transactions would not be financially feasible unless the correct support was provided when surprises arose post-transaction.

12.2. Best practice review

Grant Thornton (2010) reported that the large number of stakeholders in public services complicates the merger process and those tasked with implementation face a “minefield of complex legal and regulatory barriers to navigate”. While the findings found that Monitor was very supportive in guiding trusts through the process, the

large number of regulatory, commissioning and other approvals required delayed the process, prolonging the pre-deal period to up to two years.

Recommendations for regulators and commissioners

38. Consider allowing a longer performance holiday on a case-by-case basis or for specific areas and ensure this is respected by all regulators and commissioners involved.
39. Streamline regulatory process to reduce the timeframe needed for approvals.
40. Where multiple commissioners have conflicting views, NHS Improvement should work to support aligned commissioning.
41. Increase close working among regulators to reduce the number of approvals required.

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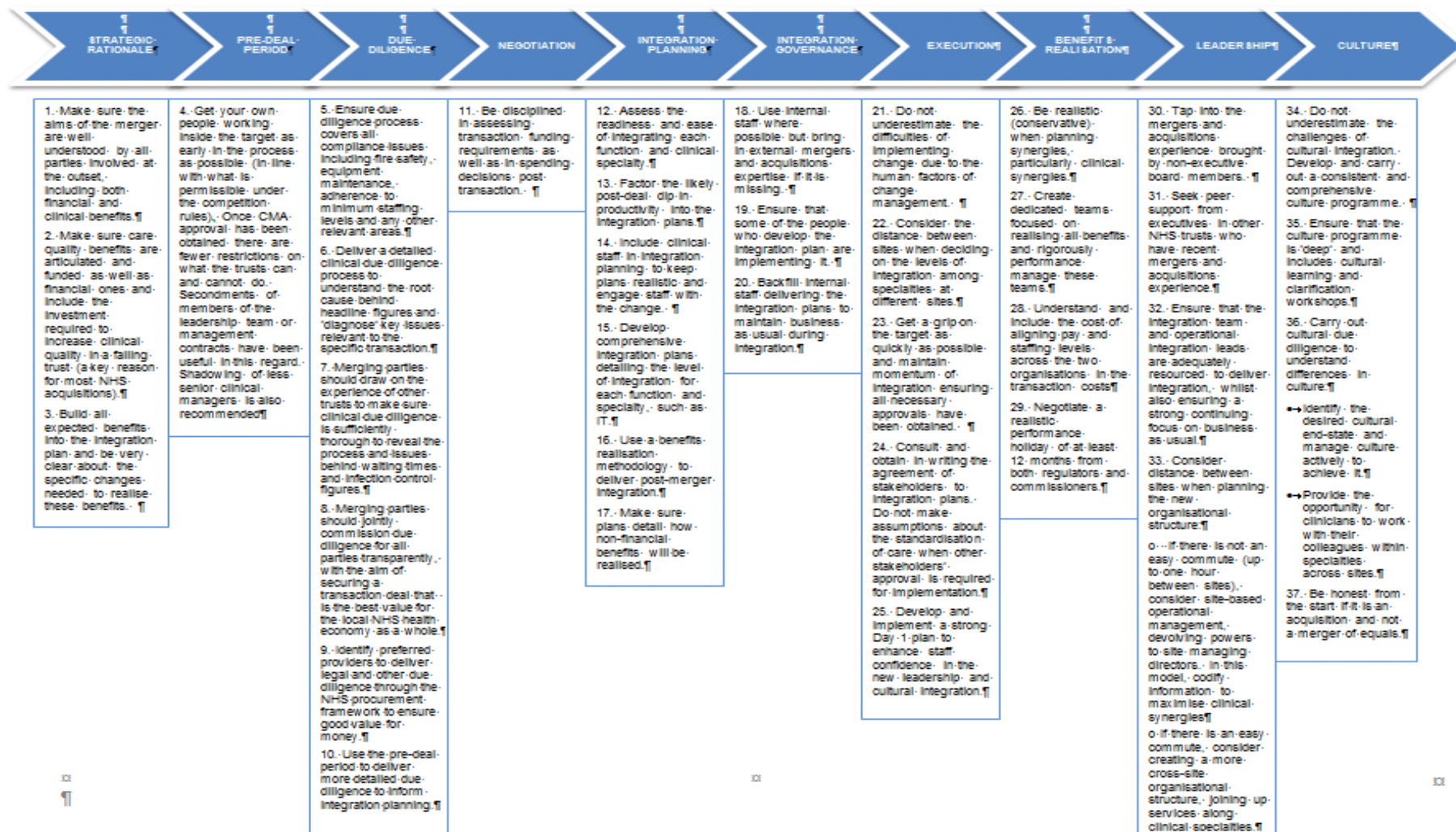
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Annex 1: Summary of recommendations for NHS trust boards (excludes recommendations for regulators and commissioners)





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