Foundation trust and NHS trust mergers

2010 to 2015

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Contents

1 Key messages

- There was a steady stream of 20 mergers involving NHS trusts and foundation trusts from early 2010 to mid-2015. Almost all were initiated by regulators or administrators, with the aim of helping NHS trusts to gain foundation trust status or to rescue providers from financial challenges.

- In most cases, mergers were pursued after a range of other strategies had been tried unsuccessfully. In many cases, organisations had reached a state of severe crisis by the time of the merger.

- Almost all of the mergers were horizontal mergers between neighbouring providers that perpetuate traditional hospital models. Few of the mergers appeared to provide the basis for radically different systems of care.

- Our review revealed serious weaknesses in organisations' assessment of alternative options and articulation of the case for merger. In a number of cases, we were unable to identify any clear rationale for merger. In many cases, the parties cited benefits that did not appear to be directly attributable to the merger or seemed unlikely to materialise.

- There appears to be widespread belief in the benefits of achieving 'critical mass', which is not supported by the available evidence. Conversely, there appears to be little recognition of the disadvantages of creating larger, more complex organisations with conflicting cultures or business models.

- Our review revealed an extremely complex and time-consuming merger approvals process. As many as 10 separate organisations were responsible for approving some recent mergers. It took some parties four or five years to identify a merger partner, gain approvals and complete the transaction.

- Nevertheless, we question whether the current system provides appropriate checks and balances. Some of the national bodies play important roles in initiating mergers before subsequently appraising the parties' business cases.

In some cases, it appears that the decisions to pursue mergers were made before the thinking on costs and benefits had been completed.

- The Department of Health and commissioners allocated close to £2 billion to only 12 mergers in the past five years. This compares to £200 million earmarked to support the new care models in the *NHS five year forward view* (**NHS England et al 2014**).

- While the financing packages are certainly very large, the amount of funding dedicated to activities related to the merger often appears very low. The vast majority of funding goes towards writing down historic debts, covering deficits and capital investment rather than achieving merger synergies.

- This casts further doubt on whether mergers are likely to address the root causes of providers' difficulties. It also raises the question whether parties pursue mergers primarily to secure financing that would not otherwise be available.

- In short, NHS leaders appear to be betting the farm on time-consuming, costly and risky transactions for failing providers, often based on faulty argumentation, and in the absence of evidence that mergers typically help to create more sustainable organisations.

- While mergers will continue to play a role in the NHS, the national bodies should rule out mergers as a route for NHS trusts to gain foundation trust status or as a response to failure, focusing instead on supporting actual service improvement and system-wide transformation.

- In most cases, there are alternative strategies that better address the underlying causes of failing providers' difficulties. These strategies should generally focus on supporting service improvement and system-wide transformation.

- One alternative approach, which we set out in a future paper (Ham and Alderwick, forthcoming), is for groups of providers to develop place-based systems of care, with the emphasis on collaboration across organisational and service boundaries to meet the needs of a defined population, while ensuring financial and clinical sustainability.

- Where providers do contemplate transactions, we need to ensure a higher standard of strategic thinking on alternative options and a realistic assessment of the costs and benefits of merger, as well as more careful consideration of how to create coherent organisations and business models.

- Monitor and the NHS Trust Development Authority need to play the role of sceptical shareholders, providing objective oversight and challenge to these plans.

2 Introduction

Mergers have reshaped the NHS since its creation. The Hospital Plan of 1962 recast a patchwork of 2,000 services into around 400 hospitals serving populations of between 100,000 and 150,000. Further waves of consolidation followed, in particular more than 100 mergers between 1997 and 2006 (**Gaynor *et al* 2012**). By the early 2000s, there were 180 acute NHS trusts delivering a wide range of services to average populations of 290,000 (**Maybin 2007**).

Our enthusiasm for mergers, and for larger hospital clusters shows little sign of abating. There were around 50 mergers involving NHS trusts, foundation trusts and primary care trusts' provider arms from 2010 to mid-2015. By 2015, the number of acute foundation trusts and NHS trusts had dropped to 150, and their average populations had risen to 350,000.

Almost every transaction has brought together neighbouring services within larger and more complex organisations. This is despite a growing body of evidence that hospital mergers typically fail to deliver the intended benefits. Research by the University of Bristol on the impact of 102 acute hospital mergers from 1997 to 2006 found that productivity remained unchanged, waiting times rose and the size of merging trusts' financial deficits increased (**Gaynor *et al* 2012**). This is consistent with much of the research on mergers in other health systems and economic sectors. Recent NHS history is littered with the remains of failed – or at least, profoundly troubled – mergers: for example, the mergers that created South London Healthcare NHS Trust, the mergers that created Barts Health NHS Trust, and King's College Hospital NHS Foundation Trust's acquisition of the Princess Royal University Hospital.

If the benefits of mergers are uncertain, the costs and difficulties of completing them are increasingly apparent. Some recent mergers took five years or more from conception to completion, before the work of improving services could begin in earnest. The Department of Health and commissioners allocated close to £2 billion in loans, public dividend capital and income to support only 12 mergers in the past five years. The actual investments will probably be substantially higher given the tendency

for mergers to be more costly and less beneficial than envisaged. In the current climate, it is more important than ever to ensure that these funds are used effectively.

At the same time, the Dalton Review (Dalton 2014), NHS England's Vanguard programme and other projects have sparked greater interest in alternative organisational models, including integrated care systems, federations, hospital chains and specialty chains. If these are the models of the future, we might ask why such a large quantity of the available funding is being used to support mergers between neighbouring trusts that, for the most part, perpetuate current models.

This paper reviews the 20 major mergers involving foundation trusts and NHS trusts from 2010 to mid-2015, excluding mergers involving primary care trusts' provider services. Our aim was to assess how the mergers process is operating at a strategic level. We consider what triggers mergers, organisations' stated rationale for mergers, the roles of various actors in assessing them and the finance packages provided to complete them. We comment briefly on implementation and outcomes although, for the most part, it is too soon to assess whether the mergers in this sample have delivered the intended benefits.

This is a rapid review rather than a detailed study. Nevertheless, it raises some significant questions for ministers, regulators and the leaders of providers about our reliance on mergers as a route for improving services, the quality of thinking on their benefits, the robustness of the decision-making process, and their costs. We drew on interviews with a small number of senior system leaders from NHS England, the Department of Health, Monitor and the NHS Trust Development Authority. We also reviewed published information on the 20 mergers, including the parties' business cases where available, and reports from regulators, special administrators and the competition authorities. We are very grateful to those involved for the time they gave to interviews and commenting on the draft report.

3 A brief overview of recent mergers

We identified 20 mergers between foundation trusts and NHS trusts from 2010 to mid-2015, including one merger that was not yet completed (Northumbria Healthcare NHS Foundation Trust's merger with North Cumbria University Hospitals NHS Trust) but excluding mergers that had been proposed but abandoned (such as the merger of the Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust and Poole Hospital NHS Foundation Trust). We considered the transfer of whole hospitals – such as University College London Hospitals NHS Foundation Trust's acquisition of the Royal National Throat, Nose and Ear Hospital – but not transfers of individual services. We also excluded the 30 or so mergers involving former primary care trusts' provider services from 2009 to 2012 as part of the Transforming Community Services programme.

Figure 1 gives a brief outline of the types of organisations involved in the 20 mergers along with the financial position of the merging parties at the time of the mergers. Table 1 provides more detail.

Figure 1 Types of organisations involved in mergers and their financial background

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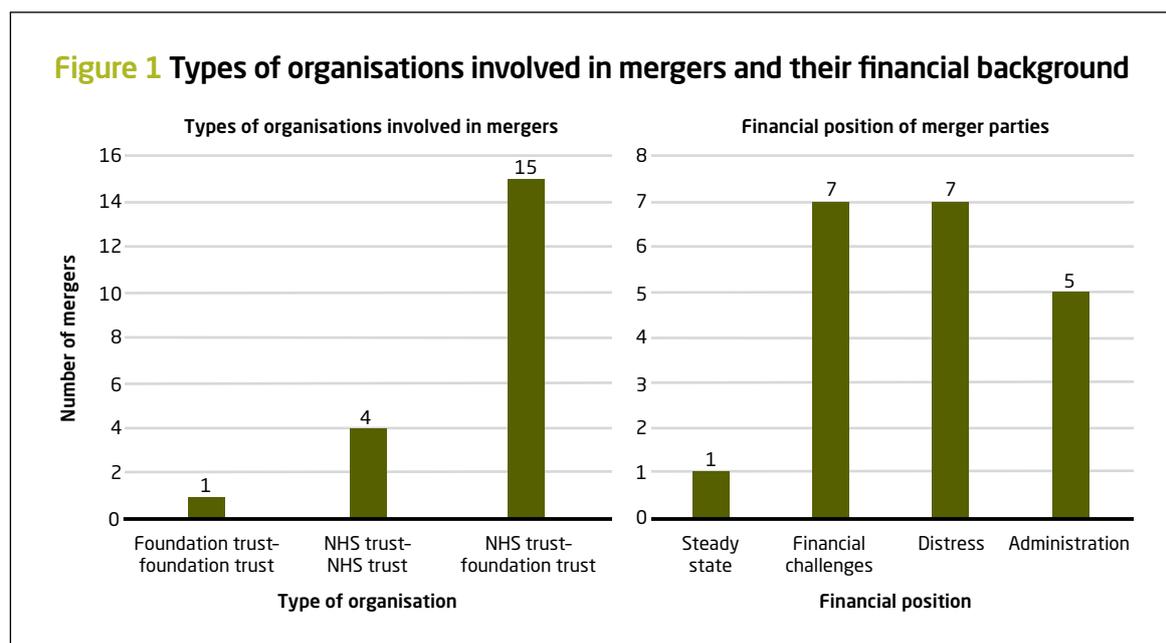
Table 1 Foundation trust (FT) and NHS trust mergers, 2010–15 (excluding mergers involving primary care trusts' provider services)

Merging organisations		Sectors	Type	Financial situation at time of merger	Date
Northumbria Healthcare FT	North Cumbria University Hospitals NHS Trust	Acute	FT–Trust	Distress (North Cumbria had recurrent deficits)	On-going
Chelsea and Westminster Hospital FT	West Middlesex University Hospital NHS Trust	Acute	FT–Trust	Financial challenge (West Middlesex had current and predicted deficits)	Sept 2015
Frimley Park Hospital FT	Heatherwood and Wexham Park Hospitals NHS FT	Acute	FT–FT	Distress (Heatherwood and Wexham had recurrent deficits)	2014
University Hospital of North Staffordshire NHS Trust	Stafford Hospital (Mid Staffordshire NHS FT)	Acute	FT–Trust	Failure (Mid Staffs had entered special administration)	2014
Royal Wolverhampton NHS Trust	Cannock Chase Hospital (Mid Staffordshire FT)	Acute	FT–Trust	Failure (Mid Staffs had entered special administration)	2014
Royal Free London NHS FT	Barnet and Chase Farm NHS Trust	Acute	FT–Trust	Distress (Barnet and Chase Farm had recurrent deficits)	2014
Ealing Hospital NHS Trust	North West London Hospitals NHS Trust	Acute/ community	Trust–Trust	Distress (North West London had recurrent deficits)	2014
King's College Hospital NHS FT	Princess Royal Hospital (South London Healthcare NHS Trust)	Acute	FT–Trust	Failure (South London had entered administration)	2013
Oxleas NHS FT	Queen Mary's Hospital (South London NHS Trust)	Community/ mental health	FT–Trust	Failure (South London had entered administration)	2013
Lewisham Healthcare NHS Trust	Queen Elizabeth Hospital (South London Healthcare NHS Trust)	Acute	Trust–Trust	Failure (South London had entered administration)	2013
South Western Ambulance Service NHS FT	Great Western Ambulance Service NHS Trust	Acute	FT–Trust	Financial challenges (Great Western had predicted deficits)	2013
University College London Hospitals NHS FT	Royal National Throat, Nose and Ear Hospital (Royal Free London NHS FT)	Acute	FT–Trust	Steady state	2012
Central Manchester University Hospitals NHS FT	Trafford Healthcare NHS Trust	Acute	FT–Trust	Distress (Trafford had recurrent deficits)	2012
York Teaching Hospital NHS FT	Scarborough and North East Yorkshire Healthcare NHS Trust	Acute	FT–Trust	Distress (Scarborough and North East Yorkshire had recurrent deficits)	2012
Barts and the London NHS Trust	Newham University Hospital NHS Trust and Whipps Cross University Hospital NHS Trust	Acute	Trust–Trust	Distress (Newham and Whipps Cross had recurrent deficits)	2012

Table 1 cont'd

Merging organisations		Sectors	Type	Financial situation at time of merger	Date
Basingstoke and North Hampshire NHS FT	Winchester and Eastleigh Healthcare NHS Trust	Acute	FT–Trust	Financial challenge (Winchester and Eastleigh had current and predicted deficits)	2012
Southern Health NHS FT	Oxfordshire Learning Disability NHS Trust	Community/ mental health	FT–Trust	Financial challenge (Oxfordshire Learning Disability Trust had current and predicted deficits)	2012
Norfolk and Waveney Mental Health NHS FT	Suffolk Mental Health NHS Trust	Mental health	FT–Trust	Financial challenge (Suffolk had current and predicted deficits)	2012
Oxford University Hospitals NHS Trust	Nuffield Orthopaedic Centre NHS Trust	Acute	Trust–Trust	Financial challenge (Nuffield had current and predicted deficits)	2011
South Essex Partnership University NHS FT	Bedfordshire and Luton Mental Health and Social Care Partnership NHS Trust	Community/ mental health	FT–Trust	Financial challenge (Bedfordshire and Luton had current and predicted deficits)	2010

Mergers as a response to failure

The most striking features of the sample are the predominance of NHS trust to foundation trust mergers and the almost universal background of financial challenge. One of the primary motivations for at least a dozen of the mergers was to allow NHS trusts to acquire foundation trust status through the transaction. Many of the NHS trusts' submissions to the Co-operation and Competition Panel for mergers up to 2013 referred to the government's foundation trust policy and deadlines for trusts to gain foundation trust status.

An overriding objective in most cases was to rescue one of the parties from financial challenges, as well as, in some cases, addressing concerns about the quality of services. One of the parties in five of the mergers had entered administration. Seven of the mergers included a provider in financial distress, by which we mean facing significant, recurrent deficits. Most of the other mergers also took place against a backdrop of growing financial difficulties. For example, interviewees explained that they saw significant clinical benefits in Chelsea and Westminster Hospital NHS Foundation Trust's merger with West Middlesex Hospital NHS Trust, although they also saw financial benefits in the context of West Middlesex's current and predicted deficits. Just a single merger – University College London Hospitals NHS Foundation Trust's

acquisition of the Royal National Throat, Nose and Ear Hospital – was pursued for strategic reasons unrelated to foundation trust policy or financial difficulties.

Regulators or special administrators initiated or strongly influenced almost all of these mergers. The NHS Trust Development Authority concluded that five of the NHS trusts in the sample would need to find merger partners. Strategic health authorities made similar decisions in relation to earlier transactions. Monitor instigated the search for a suitable acquisition partner for Heatherwood and Wexham Park Hospitals NHS Foundation Trust. Special administrators initiated the five South London Healthcare NHS Trust and Mid Staffordshire NHS Foundation Trust mergers. In a few cases, leaders of successful providers had reservations about merging with struggling trusts, but were swayed by the national bodies or a sense of duty to their local system.

Mergers at a point of crisis

In almost all cases, challenged organisations pursued mergers only after a range of other solutions had been attempted. Most of the NHS trusts in the sample had worked with consultants on multiple cost-cutting and service improvement programmes, and had submitted unsuccessful applications for foundation trust status before the decision to pursue a merger. Monitor replaced senior leaders and established a turnaround board at Heatherwood and Wexham Park Hospitals NHS Foundation Trust before it decided that a merger would be the best course of action. South London Healthcare NHS Trust was the subject of numerous strategic reviews before special administration.

By the time of the merger, many of these organisations had reached a state of severe crisis, with:

- a succession of interim senior managers

- hostile relationships between managers and clinicians

- major recruitment challenges

- reliance on locums

- run-down facilities.

Monitor's (2014a) advice to the Competition and Markets Authority on Heatherwood and Wexham Park Hospitals NHS Foundation Trust cites unstable leadership, an inability to hire permanent staff and the risk of further deterioration in the quality of services.

Replicating existing models

Almost all of the transactions were 'horizontal mergers' between neighbouring providers carrying out similar activities, rather than 'vertical mergers' between providers carrying out different activities along a value chain. (There were some vertical mergers between primary care trusts' provider services and acute hospitals as well as with mental health providers from 2009 to 2011.) In most cases, the mergers brought together large organisations in their entirety, rather than parts of them or particular service lines. In all cases, the mergers brought together neighbouring providers serving overlapping or contiguous populations.

In short, almost all of the transactions appear largely to perpetuate the traditional model of large, full-service hospital trusts, delivering a broad range of services in a single locality. Few of the mergers appeared designed to establish a fundamentally different business model or system of care, such as the integrated health systems or population health approaches described in the *NHS five year forward view* (NHS England *et al* 2014). Very few of the mergers provided the basis for providers currently delivering a large range of services to introduce greater focus or specialisation. None provided the basis for the development of regional or national chains based on a defined operating model.

Conclusions on the pattern of recent mergers

Our overview highlights the role of national bodies in orchestrating mergers and their reliance on mergers as a last-ditch response to financial failure. We might question why the regulators view mergers as an effective response for providers with the most intractable problems, given their poor record of success. We might also question the reliance on horizontal mergers between hospitals in cases where radical restructuring of the local system appears to be needed.

4 The strategic rationale for recent mergers

We carried out a rapid review of the stated rationales for 19 of the 20 mergers in the sample, based on publicly available documents such as administrators' and regulators' reports and publications by the merging organisations. (We were unable to find any documents on one of the earlier transactions in the sample.) There is quite limited information available on the rationale for many of these mergers, despite the large public investments in some of them. There is a little more information in the few examples where the parties published their full business case or where the competition authorities carried out a detailed investigation. The results of the review are outlined in Figure 2.

Figure 2 Rationales for foundation trust and NHS trust mergers, 2010–15
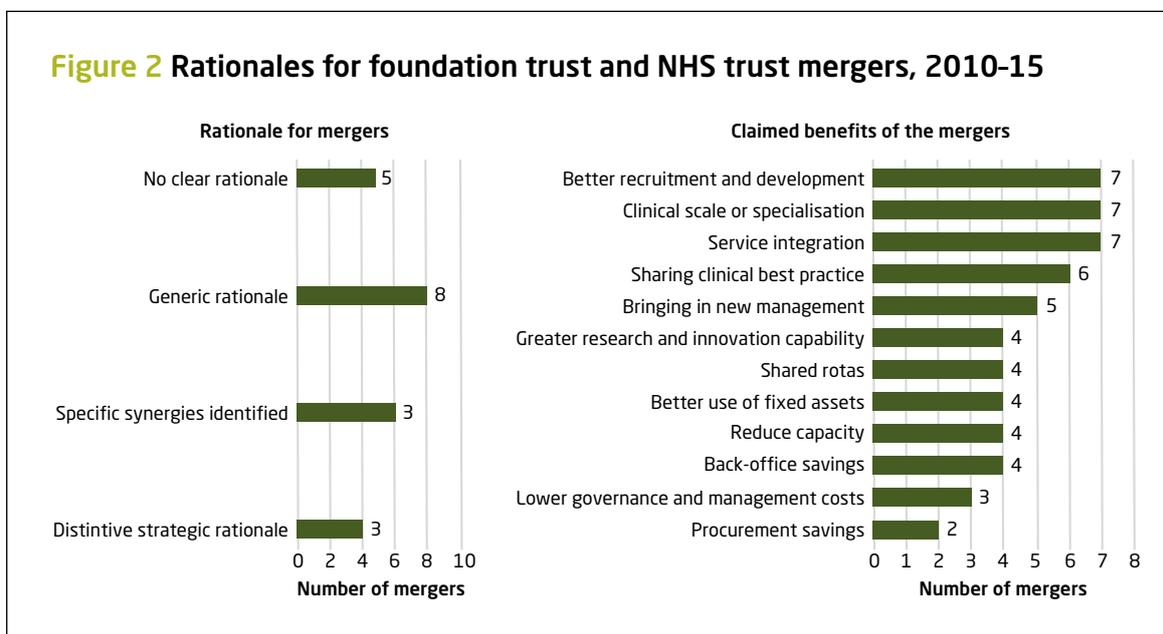
A high-level assessment of the case for merger

We were unable to identify a clear rationale for five of the mergers in the sample, at least from the publicly available documents. For example, the special administrator's report on South London Healthcare NHS Trust explains the rationale for changes

to the configuration of services, such as the closure of accident and emergency services at Lewisham. However, it does not explain in detail the rationales for or specific benefits of transferring the Princess Royal University Hospital, Queen Mary's Hospital or Queen Elizabeth Hospital to new providers. On the contrary, the report explicitly recognises that the efficiencies from combining these hospitals with their neighbours would be limited (Department of Health 2013). The main objective appears, understandably, to be to find safe harbours for South London's services even if there weren't substantial benefits from the mergers themselves.

In eight cases, our assessment was that the authorities or the merging parties had set out a 'generic rationale for merger' rather than a specific benefits case. Many of the providers' documents cite long lists of efficiencies that might potentially arise from bringing two organisations together, such as:

- improving recruitment

- investing in research

- sharing best practice

- greater clinical specialisation.

However, they do not explain in detail how they would secure them or why they thought they were substantial.

In three of the cases, the parties had identified 'specific synergies' from the merger in particular areas. For example, Northumbria Healthcare NHS Foundation Trust identified opportunities through merger with North Cumbria University Hospitals NHS Trust to redesign stroke services, acute medicine, end-of-life care, trauma and orthopaedic services. It also set out in some detail how it planned to do so (Northumbria Healthcare NHS Foundation Trust and North Cumbria University Hospitals NHS Trust 2012).

In our view, very few of the merging parties could claim to have set out a 'distinctive strategic rationale' for the merger (as opposed to tactical plans to exploit improvement opportunities as a combined organisation) such as the opportunity

to develop a specific business model or a fundamentally different system of care. One exception might be University College London Hospitals NHS Foundation Trust, which saw opportunities to create a specialist centre for head and neck services through its acquisition of the Royal National Throat, Nose and Ear Hospital (University College London Hospitals NHS Foundation Trust 2011).

Specific arguments to justify mergers

Installing high-quality management was one of the main reasons for a number of the transactions. Our interviewees suggested that this was the most important reason for the Royal Free London NHS Foundation Trust's merger with Barnet and Chase Farm Hospitals NHS Trust. Monitor's (2014a) advice to the Competition and Markets Authority suggests that this was the main reason for Frimley Park Hospitals NHS Foundation Trust's takeover of Heatherwood and Wexham Park Hospitals NHS Foundation Trust. As discussed below, we question whether it is proportionate to embark on costly, time-consuming and risky transactions simply to put a new management team in place.

In other cases, providers argued that the merger would deliver reductions in governance or general management costs. For example, the business case for Barts and the London NHS Trust's merger with Newham University Hospital NHS Trust and Whipps Cross University Hospital NHS Trust suggested that the merger would lead to savings in corporate pay of £13 million over four years. These were the most important savings that the parties hoped to achieve, representing 40 per cent of the savings from the merger (Barts and the London NHS Trust *et al* 2011). Again, we might question whether merging complex organisations is likely to deliver substantial savings in these areas. Research from the early 2000s showed that the management savings from NHS mergers were highly variable and, while they existed, were much lower than expected (Fulop *et al* 2002).

Many of the documents appear to see a wide range of inherent benefits in creating larger organisations, with statements suggesting that achieving 'critical mass' should make it significantly easier to:

- recruit staff

- develop partnerships

- improve services

- ensure financial sustainability.

While it is possible to put forward theoretical arguments that mergers will lead to these types of benefits, there is little empirical evidence that they often materialise in practice. Research from the early 2000s found that hospital mergers did not make it any easier to recruit or retain staff (Fulop *et al* 2002). Monitor's (2014b) research on smaller hospitals found only a weak correlation between size and financial performance. As discussed above, other research suggests that mergers are more likely to damage trusts' finances than improve them (Gaynor *et al* 2012).

A number of the documents point to benefits that do not appear to be directly attributable to the merger or which, at the least, appear achievable without the merger. For example, providers cited improvements to stroke and cancer care that could be, and in some cases were already, being pursued through co-operative networks rather than by merging. Some acute hospitals argued that their mergers would make it easier to integrate with primary and community care, even when these providers were not involved. In other cases, the participants argued that the merger would allow them to close down spare capacity, without explaining why they could not simply transfer individual services from one organisation to another. (Some have argued that it is easier to rationalise services within a merged organisation in practice, but the evidence is far from conclusive.)

Potential disadvantages of creating larger, more complex organisations

Some of the mergers in the sample created extremely large, complex organisations delivering very different types of services. The merger of Barts, Newham and Whipps Cross brought together:

- specialist centres

- 'full-service' district general hospitals

- 'manufacturing plants' for elective operations

- community teams.

According to the NHS Trust Development Authority, the merger of North West London Hospitals NHS Trust and Ealing Hospital NHS Trust would mean that 'patients would rarely have to travel outside the new Trust's boroughs for services' (NHS Trust Development Authority 2014b).

None of the documents we reviewed recognised any potential disadvantages in creating larger and more complex organisations. Nevertheless, it would be as easy to point to potential diseconomies of scale, scope or complexity as to potential efficiencies in many of these mergers, for example:

- the potential lack of strategic focus associated with diversified firms

- the increasingly bureaucratic decision-making in some large corporations

- the challenges of bringing together contrasting business models and cultures under the same roof.

Conclusions on the rationale for mergers

In our view, many organisations in the sample struggled to articulate a persuasive rationale for their mergers, at least in their public documents, despite requiring many millions in public investment. Others have reached similar conclusions where there has been a detailed, independent assessment of the case for merger. For example, the Co-operation and Competition Panel questioned how merger would address the difficulties faced by Barts, Newham and Whipps Cross: 'It is not clear how the merger will help overcome those challenges and indeed in our view a merger of this complexity will present challenges of its own' (Co-operation and Competition Panel 2011).

5 The mergers approval process

Following the Health and Social Care Act 2012, the national bodies have started to clarify their roles and refine their procedures for approving mergers. Monitor and the NHS Trust Development Authority agreed a memorandum of understanding on joint working in 2013 and have published updated guidance on their approvals processes and how they fit together (Monitor 2015; NHS Trust Development Authority 2015). However, our interviewees recognised that they were still in the process of developing roles that were not set out in detail in the legislation. They also acknowledged that the process varied for every merger, particularly those in distress or administration (*see* Figure 3).
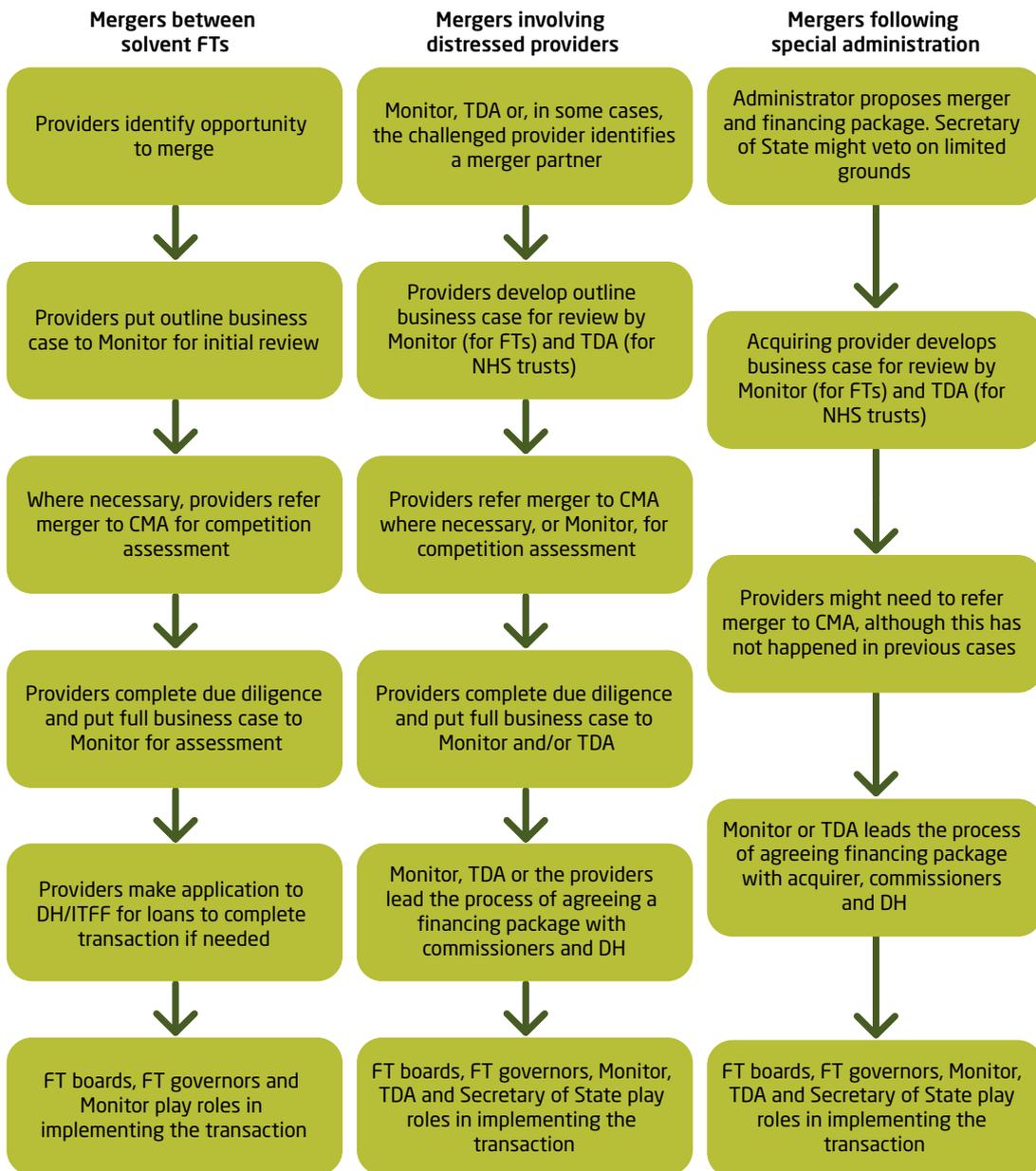
Mergers between 'stable' providers

At least in theory, foundation trusts and NHS trusts are expected to play the leading role in assessing strategic options and developing merger plans when they are financially and clinically stable. For example, University College London Hospitals and the Royal Free decided on the former's acquisition of the Royal National Throat, Nose and Ear Hospital. West Middlesex University Hospital NHS Trust identified Chelsea and Westminster Hospital NHS Foundation Trust as its preferred merger partner, albeit after an NHS Trust Development Authority decision that it was unviable on its own.

In these circumstances, Monitor and the NHS Trust Development Authority play an oversight role, reviewing the parties' business cases and approving the transaction for foundation trusts and NHS trusts respectively. In its approval process, Monitor assesses:

Figure 3 Overview of merger approvals for solvent foundation trusts, distressed providers and those in administration

Mergers between solvent FTs	Mergers involving distressed providers	Mergers following special administration
Providers identify opportunity to merge	Monitor, TDA or, in some cases, the challenged provider identifies a merger partner	Administrator proposes merger and financing package. Secretary of State might veto on limited grounds
Providers put outline business case to Monitor for initial review	Providers develop outline business case for review by Monitor (for FTs) and TDA (for NHS trusts)	Acquiring provider develops business case for review by Monitor (for FTs) and TDA (for NHS trusts)
Where necessary, providers refer merger to CMA for competition assessment	Providers refer merger to CMA where necessary, or Monitor, for competition assessment	Providers might need to refer merger to CMA, although this has not happened in previous cases
Providers complete due diligence and put full business case to Monitor for assessment	Providers complete due diligence and put full business case to Monitor and/or TDA	Monitor or TDA leads the process of agreeing financing package with acquirer, commissioners and DH
Providers make application to DH/ITFF for loans to complete transaction if needed	Monitor, TDA or the providers lead the process of agreeing a financing package with commissioners and DH	FT boards, FT governors, Monitor, TDA and Secretary of State play roles in implementing the transaction
FT boards, FT governors and Monitor play roles in implementing the transaction	FT boards, FT governors, Monitor, TDA and Secretary of State play roles in implementing the transaction	

Notes: CMA = Competition and Markets Authority, DH = Department of Health, FT = foundation trust, ITFF = Independent Trust Financing Facility, TDA = NHS Trust Development Authority.

- the strategic rationale for the merger

- the foundation trust's ability to implement the transaction

- the effect on service quality

- the impact on financial viability.

It then issues a transaction risk rating, which must be amber or green for the merger to proceed. The NHS Trust Development Authority carries out a similar assessment through the gateway review process in its accountability framework. In steady state, the providers might apply directly to the Department of Health for a loan to support post-merger integration where this is needed. (For example, Chelsea and Westminster Hospital NHS Foundation Trust applied directly to the Department for funding for its merger with West Middlesex University Hospital NHS Trust.)

Mergers involving distressed providers

However, as discussed above, at least one of the providers in many recent mergers has faced significant financial challenges. In these cases, either Monitor or the NHS Trust Development Authority typically plays a more active role in determining strategy and identifying a merger partner. Monitor initiated the search for a merger partner for Heatherwood and Wexham Park Hospitals NHS Foundation Trust. Meanwhile, the NHS Trust Development Authority played an active role in the competitive process that identified the Royal Free London NHS Foundation Trust as the preferred merger partner for Barnett and Chase Farm Hospitals NHS Trust.

In these cases, the merging parties often require a substantial financing package to implement the transaction. According to interviewees, Monitor or the NHS Trust Development Authority typically plays the role of 'broker', helping to reach an agreement on the package between providers, the Department of Health and commissioners. They are responsible for ensuring that the package offers value for money and presenting it to the Department of Health and other funders for approval.

Mergers following special administration

In special administration, the administrator is responsible for devising a plan for ensuring that patients can access services, including any proposals to transfer the failing organisation's services to other providers. In these cases, the acquiring trust is usually responsible for developing a business case and carrying out due diligence. Monitor or the NHS Trust Development Authority reviews its business case and the acquirer's readiness for the transaction.

In special administration cases, the administrator is also responsible for developing a financing package needed to complete the merger. However, as above, Monitor or the NHS Trust Development Authority typically acts as the 'broker' who helps to secure agreement on the final package between the merging parties and funders, before putting the package to the Department of Health for approval.

Roles of the Department of Health and other bodies

The Department of Health's main role is to review and agree the financing packages for large mergers and ensure that they offer value for money. In some cases, the Independent Trust Financing Facility has advised on the financing packages for mergers. (For example, it did so for the Royal Free's acquisition of Barnett and Chase Farm and Frimley Park's acquisition of Heatherwood and Wexham Park.) It did not look at the mergers following special administration, as these were seen as 'too political'. Both the Independent Trust Financing Facility and the Department of Health rely heavily on advice from Monitor or the NHS Trust Development Authority on whether the financing package offers value for money. The Treasury is also actively involved in approving larger financing packages, such as those following special administration.

As our interviewees explained, NHS England and clinical commissioning groups have started to play a more active role in agreeing mergers. For the Department of Health, it was important to ensure that commissioners were strongly supportive of mergers and demonstrated their commitment by contributing to the financing package. Commissioners are now expected to cover at least some of the costs of clinical change and double-running costs (the costs of running two services at the same time during the transition from one service to another). According to interviewees, clinical commissioning groups are often reluctant to do so.

In addition to these processes, the Health and Social Care Act 2012 made clear that the Competition and Markets Authority is responsible for reviewing the impact of mergers involving foundation trusts where they qualify under the Enterprise Act 2002. (Before the 2012 reforms, the Co-operation and Competition Panel reviewed these mergers under an administrative rather than a statutory framework.) Providers generally refer qualifying mergers to the Competition and Markets Authority for assessment after they have developed their outline business case. The Authority assesses the impact of the merger on competition and, where the merger results in a significant lessening of competition, whether there are countervailing benefits for patients. The Authority did not review any of the mergers that followed the South London or Mid Staffordshire administration processes. However, as far as we are aware, it might do so in future cases.

Complexity of the approvals process

One particularly striking feature of the new system is the number of parties that are involved in agreeing to transactions. For example, no fewer than 10 different organisations played important roles in approving the merger between Chelsea and Westminster Hospital NHS Foundation Trust and West Middlesex University Hospital NHS Trust.

- Monitor and the Trust Development Authority were both responsible for approving the parties' business cases.

- The Competition and Markets Authority reviewed the impact on competition.

- The Department of Health, NHS England and three clinical commissioning groups needed to agree to the financing package.

- The boards of the two providers needed to approve the transaction.

- Chelsea and Westminster Hospital NHS Foundation Trust needed to secure the agreement of most of its governors.

There is a lack of clarity regarding the roles that different organisations are supposed to play in the process or how they differ from each other. Some interviewees described their roles in the language of commercial transactions, referring to

'brokers', 'vendors' and 'acquirers'. In practice, most organisations with an approval role appear to make the same assessment of whether a merger is in the public interest, rather than evaluating it from different perspectives.

Under these circumstances, it may not be surprising that it has taken a considerable amount of time to complete many of the mergers in the sample. It can take one to two years for providers to identify their preferred merger partner, and one to four years to gain approvals and complete the merger. The process appears particularly complex when both Monitor and the NHS Trust Development Authority need to approve mergers of foundation trusts and NHS trusts through separate review processes (although they have improved how they work together) and when a number of clinical commissioning groups need to agree the funding package. (The timescales were a little shorter in the two special administration cases.)

By way of example, Ealing Hospital NHS Trust and Northwest London Hospitals NHS Trust agreed to pursue their merger in October 2010, and completed the merger four years later in October 2014. The trusts believed that they would be able to complete the post-merger integration process in two years. The London Strategic Health Authority concluded that West Middlesex University Hospital NHS Trust was unsustainable as an independent organisation in February 2012. The trust identified Chelsea and Westminster as its preferred partner in April 2013. The two trusts completed the merger in September 2015.

Our interviewees expressed different views about the advantages and disadvantages of involving so many organisations in the decision-making process. Some argued that there were benefits in maintaining a degree of creative tension and challenge. Others argued that the current system lends itself to duplication of effort, difficult negotiations and delays. Some interviewees contended that the regulators and funders should operate as a single entity, using a single set of advisers, to assess whether mergers are in the public interest and determine a funding package that delivers value for money.

Potential conflicts of interest

There is a body of literature on the agency problems and cognitive biases that can contribute to poor decision-making in relation to mergers, procurement or auction processes, and investment projects. Economists have highlighted managers' personal

incentives to pursue mergers, win contracts or make major capital investments.(for example, *see* Jensen 1986). Behavioural psychologists have pointed to optimism bias in the business cases for mergers and major projects, as well as commitment bias, where managers find it increasingly difficult to cancel projects after they have made substantial investments in pursuing them (for example, *see* Lovallo and Kahneman 2003). It is therefore important that shareholders or others are able to test and challenge merger proposals.

Despite the large number of organisations involved, our system does not appear well designed to provide this impartial oversight and challenge. In particular, this is because Monitor and the NHS Trust Development Authority often play a significant role in devising the initial strategy to pursue a merger and identifying the preferred merger partner, before subsequently reviewing the providers' rationale and approving their business cases for the merger. (Monitor and the NHS Trust Development Authority also have other responsibilities that might hinder objective decision-making, such as the NHS Trust Development Authority's objective of supporting NHS trusts in achieving foundation trust status.)

For example, Monitor participated in identifying Frimley Park Hospital NHS Foundation Trust as the preferred provider to acquire Heatherwood and Wexham Park Hospitals NHS Foundation Trust and supported the trusts in developing their merger plans, before approving Frimley's business case for the merger through its risk assessment process. In this case, Monitor established separate teams with Chinese walls to develop the merger plans and appraise the business case. Nevertheless, it is difficult to envisage either Monitor or the NHS Trust Development Authority vetoing mergers that they themselves had initiated and championed over a number of years.

Monitor's and the NHS Trust Development Authority's guidance documents present a sequential process where parties identify potential merger partners, and develop an outline business case, which is subject to testing and challenge, before building a full business case, which is subject to detailed scrutiny before being approved or rejected. Given the roles that Monitor and the NHS Trust Development Authority play in initiating and approving mergers, we might question whether they typically follow such an orderly process in practice.

Some of the published documents suggest that regulators and providers agreed on the mergers before developing the detailed thinking to justify them. For example, Monitor's submission to the Competition and Markets Authority on Frimley Park's acquisition of Heatherwood and Wexham Park strongly supported the transaction while acknowledging that the parties were still developing their plans for achieving improvements through the merger. It advocated the merger while recognising that 'on the information available to us we are not able to determine that any relevant customer benefits for the purposes of the Enterprise Act will arise' (**Monitor 2014a**). Monitor approved the merger following review of Frimley's business case six months later in September 2014 (**Monitor 2014c**).

Conclusions on the approvals process

Our analysis raises concerns regarding both the efficiency of the approvals process and the authorities' ability to provide an objective and impartial review of providers' merger plans. We question whether the various national bodies would have sufficient independence from previous decisions to veto many of the mergers in the sample at the full business case stage. Indeed, we were not able to identify any cases from 2010 to 2015 where Monitor or the NHS Trust Development Authority rejected a proposed merger at the full business case stage – the point when their substantive reviews of the rationale and benefits of the merger are supposed to take place.

6 Financing packages for NHS mergers

We collated the limited publicly available data on the financing packages for the 20 mergers in the sample, drawing in particular on: the NHS Trust Development Authority's reports on the final financing packages for South London Healthcare NHS Trust and Mid Staffordshire NHS Foundation Trust; the parties' business cases for the mergers where available; and press reports where necessary. We were able to gain information on the overall packages for 12 of the mergers and more detailed information on the packages for nine of them.

Overall investments to support transactions

We calculate that the Department of Health, NHS England and commissioners have allocated close to £2 billion in finance to only 12 of the 20 mergers over the past five years (*see* Figure 4). In most cases, the Department of Health appears to have contributed the majority of the funding in the form of public dividend capital. In some cases, it also contributed funding in the form of loans. NHS England and clinical commissioning groups have made substantial contributions in the form of revenue, particularly for some of the more recent mergers. In most cases, the funding has been spread over four to five years.

The total funding for recent mergers must be much higher than these figures suggest. We do not have information on the financing packages for a large number of the mergers in the sample, such as Central Manchester University Hospitals NHS Foundation Trust's acquisition of Trafford NHS Trust, which seems likely to have received substantial support.

Moreover, it seems inevitable that the funding for almost all the mergers in the sample will, in practice, be much larger than was originally envisaged. There is a consistent trend of overestimating the benefits of mergers and underestimating the time and costs of implementing them, leading to revised calculations and additional funding soon after – and sometimes before – the mergers have been completed. The

Figure 4 Total financing packages for 12 mergers, 2010–15
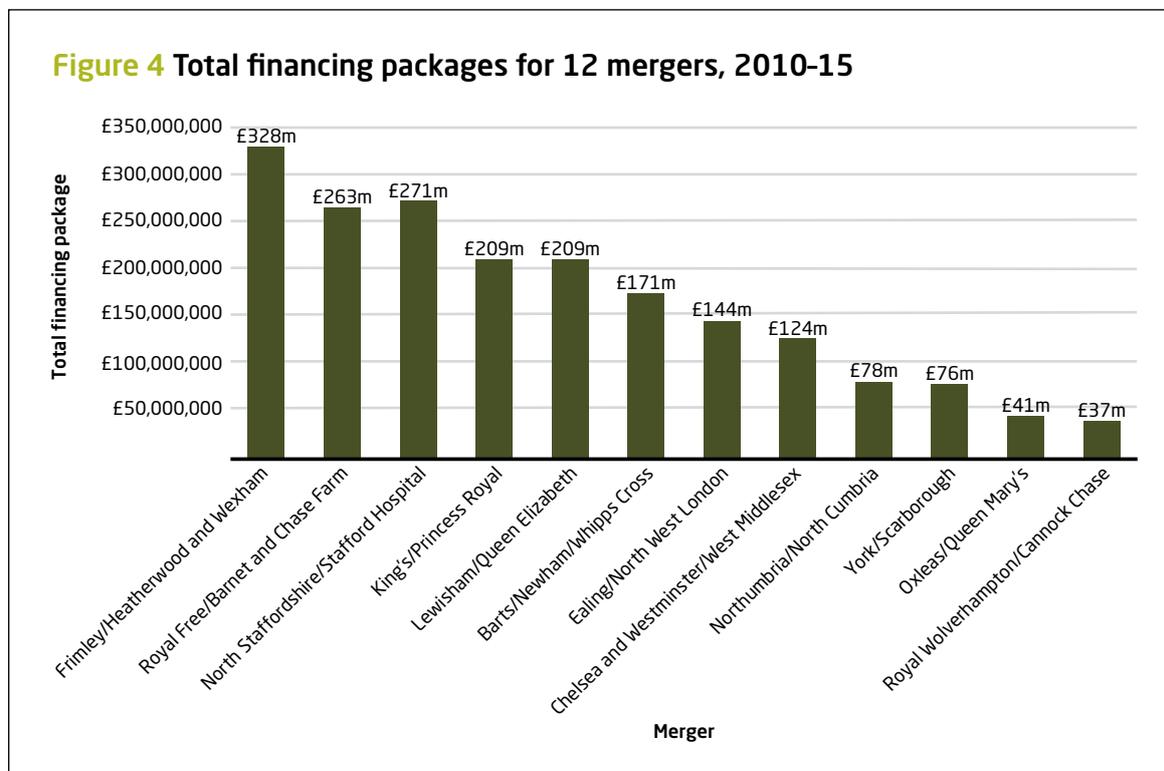
final packages for the two Mid Staffordshire mergers were £93 million higher than the special administrator had envisaged (**NHS Trust Development Authority 2014a**), while the final packages for the three South London mergers were £151 million higher than the administrator had envisaged (**NHS Trust Development Authority 2013**).

The NHS Trust Development Authority's report on the Ealing and North West London merger presents the financial benefits of the merger as a near certainty (against a benchmark that assumes that the parties would not be able to achieve any new savings as standalone organisations). According to the report, 'sensitivity tests have been applied and there is a high degree of confidence that the value for money test for proceeding with the transaction, against the non-merger benchmark, is robust' (**NHS Trust Development Authority 2014b**). Yet the new Trust's deficit, which was predicted to be £35 million for 2014/15, had risen to £55.9 million by the end of the financial year (Barnes 2015), a 60 per cent increase less than a year after the package was agreed. We imagine that worsening NHS finances might account in part for this increase. However, it is hard to believe that this could be the sole explanation for such a significant change.

Some interviewees suggested that the administration processes for South London and Mid Staffordshire had contributed to the trend of ever-larger financing packages, by demonstrating that providers could negotiate very large sums to take over struggling trusts. In some cases, interviewees believed that acquiring providers were able to 'hold funders to ransom' to extract generous financing, particularly where there were no obvious alternative merger partners. (For their part, acquirers might argue that they assume substantial risks when taking over challenged providers, and the transformation costs and deficits are often much higher than anticipated.) Interviewees suggested that the abolition of primary care trusts and strategic health authorities had also contributed to the trend of larger financing packages, by removing other, less transparent forms of support for trusts such as additional one-off revenue payments.

Composition of funding packages

The funding packages for mergers typically include:

- pre-acquisition funding, including the 'transaction costs' of planning and completing the merger

- one-off funding for the costs of integrating the two organisations and implementing improvement plans

- capital investment, typically to rebuild facilities or put in place new information technology infrastructure

- funding to write down historic debts and recapitalise the new organisation

- funding to cover future deficits, which should taper out as the transformation process is completed and the savings start to be realised.

Figure 5 provides an overview of the financing packages for nine mergers, showing the proportion of funds allocated to capital investment, transformation and integration, recapitalising the organisation, and funding future deficits. Table 2 shows a more detailed breakdown for the Barts, Newham and Whipps Cross merger (**Barts *et al* 2011**) and Frimley Park's acquisition of Heatherwood and Wexham Park (Clover and Barnes 2015). (We have included the costs of writing down providers'

Figure 5 Breakdown of financing packages for nine mergers

Breakdown of financing for nine mergers

Breakdown of financing across the nine mergers

Legend:
- Funding future deficits
- Capital investment in information technology
- Service transformation and post-merger integration
- Recapitalising the organisation
- Other
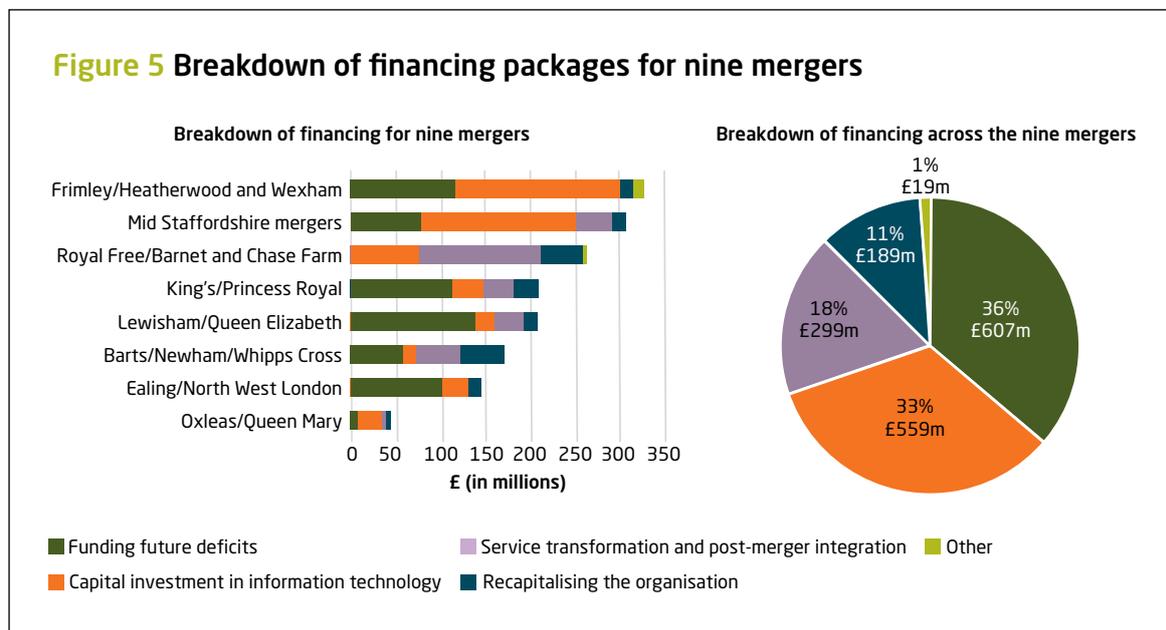
debts at the time of the merger. We have not included the costs of administration or the administrators' fees.)

While the financing packages are certainly very large, the amount of funding dedicated to the challenges of completing and securing benefits from the merger often appears extremely low. For the nine mergers discussed above, only 18 per cent of the funding appears to relate to service transformation and post-merger integration. Moreover, it is unclear how much of the funding in this category is focused on securing benefits from the merger itself, as opposed to supporting service transformation that could be delivered without the merger.

In the case of Frimley Park's acquisition of Heatherwood and Wexham Park, it seems that just £14 million of the £328 million financing package was earmarked for the merger and integration process, of which £4 million was to cover legal and advisory fees. The package for Ealing's merger with North West London does not appear to include any funding for post-merger integration (*see* NHS Trust Development Authority 2014b).

The packages include substantial funding, accounting for 33 per cent of the total, for capital investments in facilities and infrastructure. These investments also often appear largely unrelated to the merger itself. For example, Frimley Park negotiated

Table 2 Breakdown of financing packages for two mergers

Funding for Frimley's acquisition of Heatherwood and Wexham		
Type of investment	**Description of investment**	**Amount**
Capital investment	Funding to support rebuilding and refurbishment of parts of the Heatherwood site	£127.2m
	Funding to support rebuilding and refurbishment of parts of the Heatherwood site	£59.0m
Transformation and merger integration	Funding for project management office and turnaround team	£10.0m
Recapitalising the organisation	Funding for working capital normalisation	£12.0m
Funding future deficits (and similar)	Funding to cover the deficits the merged organisation is expected to run until 2020/21	£91.1m
	Funding for transaction indemnities	£24.8m
Transaction costs	Advisory costs and legal fees	£4.0m
Total		£328.1m

Funding for Barts, Newham and Whipps Cross merger		
Type of investment	**Description of investment**	**Amount**
Capital investment	Funding to meet shortfall in Whipps Cross capital programme	£14.0m
Transformation and merger integration	Funding for redundancy costs	£10.8m
	Integration project costs	£39.2m
Recapitalising the organisation	Funding to address liquidity gap	£0.4m
	Repayment of historic loans for Newham and Whipps Cross	£26.3m
	Additional working capital for Whipps Cross	£10.0m
	Additional working capital for Newham	£8.0m
	Funding to write down Whipps Cross's deficit at point of merger	£6.0m
Funding future deficits (and similar)	Funding for increased NHSLA CNST costs post-merger	£2.5m
	Funding to cover future deficits in transition	£21.3m
	Funding to ensure new organisation has required surplus	£7.3m
	Funding for additional PDC dividend costs	£5.4m
	Support for PFI costs	£20.0m
Total		£171.2m

Notes: CNST = Clinical Negligence Scheme for Trusts, NHSLA = NHS Litigation Authority, PDC = public dividend capital, PFI = Private Finance Initiative.

substantial funds to rebuild facilities at Heatherwood and Wexham Park after what it called 'chronic underinvestment' (Frimley Park Hospital NHS Foundation Trust 2013).

These findings raise further questions about the rationale for some of the mergers in the sample and the benefits they are supposed to deliver. In many cases, the financing packages confirm the impression that merger does not address the

struggling providers' underlying challenges. In other cases, we doubt whether the parties could achieve substantial synergies through the merger while dedicating limited funds to the post-merger integration process.

Transaction costs of mergers

The published documents do not generally identify clearly the transaction costs of completing the mergers. However, it appears that these are quite significant (albeit small in comparison with the overall funding package) in many cases. For example, we know that Frimley Park spent £4 million in legal and advisory fees in its acquisition of Heatherwood and Wrexham Park.

For the most part, these fees do not appear unusually high in comparison with major transactions in other sectors. However, they remind us of the substantial costs involved in pursuing a merger. (The advisory fees are, of course, just a small proportion of the total costs of completing the transaction.) In some cases, interviewees explained that the providers had hired separate firms to carry out identical due diligence processes. It is hard to see why two NHS organisations should commission duplicate work at additional cost to the taxpayer.

Types of finance available through mergers

It is clear from the sample that providers can access much larger funding packages through mergers than would normally be available to support turnaround or transformation without a transaction. Foundation trusts and NHS trusts might normally be able to access tens of millions, rather than hundreds of millions, in the form of loans for a capital investment. Moreover, they need to demonstrate the ability to repay the loan (Department of Health 2015).

It is also clear that providers can access a much wider range of finance for much broader purposes than is normally available outside mergers, including public dividend capital to recapitalise the organisation and fund future deficits. For the nine mergers discussed above, 47 per cent of the funding was aimed at writing down historic debts, providing working capital and covering future deficits. As discussed above, the financing packages often include substantial capital investment that would have been needed irrespective of the merger. In some cases, the transaction provides a basis for renegotiating with commissioners the payments for services.

For example, NHS England provided additional revenues for maternity services at Mid Staffordshire.

This raises the question of whether organisations pursue mergers primarily as a way of securing the large financing packages needed to turnaround failing trusts, rather than because they see merger, in itself, as the solution to the trusts' difficulties. Some interviewees recognised that it was easier for organisations to secure substantial funding packages as part of a merger than without one. Interviewees reflected that it might have been more effective to 'fix the roof while the sun was shining' in some of the cases we studied, rather than waiting until the provider had failed before providing a substantial financing package through a merger.

Conclusions on the financing packages for mergers

Our review of the financing for recent mergers highlights both the huge size of the financing packages and the small amounts of funding allocated to activities related to the merger. It adds further weight to our suspicions that mergers are not needed and fail to address the root causes of providers' difficulties in many cases. It also suggests that organisations might be pursuing mergers primarily as a route for securing large financing packages, rather than because of the supposed benefits of the transaction. If providers do have genuine plans to achieve synergies through merger, it appears that insufficient funding is being allocated to the post-merger integration process.

7 Conclusions and recommendations

Our review paints a picture of a highly centralised and politicised system where providers pursue mergers at the instigation of national bodies, often in pursuit of foundation trust status or in response to financial or clinical failure. Hard-pressed NHS leaders appear to be betting the farm on mergers for severely challenged providers, typically after a range of alternative strategies have been attempted.

This is despite the paucity of evidence that mergers offer lasting solutions for challenged hospitals. Our review has highlighted the length of time, costs and risks involved in mergers. Others have shown that mergers are unlikely to deliver the intended benefits.

At the same time, our review has highlighted significant weaknesses in how NHS organisations weigh alternative options and articulate the rationale for mergers, as well as in the regulatory oversight and approval of major transactions. In many cases, the published documents presented questionable justifications for mergers and over-optimistic projections, while ignoring the disadvantages and underestimating the risks. Our analysis of the benefits cases and the financing packages casts doubt on whether mergers were likely to address the root causes of providers' difficulties in many of the cases we studied.

There have of course been successful mergers both within the English NHS and other health systems: for example, University College London Hospitals NHS Foundation Trust's acquisition of specialist hospitals over the past two decades. We imagine that some of the twenty mergers over the past five and a half years will be successful too. However, policy-makers and the leaders of providers need to recognise that, based on a large body of evidence, successful mergers are the exception rather than the rule.

Under these circumstances, it is increasingly difficult to justify the burgeoning amount of funding being dedicated to mergers, rather than to other potentially

more effective approaches to transformation. The £2 billion allocated to 12 mergers over the past five years compares to £200 million to support the new models in the *NHS five year forward view* (**NHS England** *et al* **2014**). In retrospect, it is legitimate to ask what might have been achieved if such large sums and leadership time had been used to restructure the local system without the distractions of a merger.

NHS providers run into difficulties for many reasons, including:

- external factors such as funding for services

- internal factors such as poor leadership or failure to improve productivity

- historic factors such as past investment decisions.

We are unconvinced that mergers often provide an effective or proportionate response to these challenges, even when other strategies have been tried unsuccessfully. In most cases, there are alternative approaches that better address the root causes of failure without the costs, risks and delays that mergers entail (*see* Table 3).

By way of example, it does not seem proportionate to pursue mergers between large, complex organisations simply to secure a stable, high-quality management team for a failing provider. There is little evidence that senior managers are underemployed within successful providers, with time on their hands to turn around failing organisations. On the contrary, research has shown that mergers can weaken leadership and governance by distracting leaders from their roles in overseeing services (**Audit Commission 2006**). Recent examples highlight the risk that mergers destabilise the acquiring provider rather than rescuing the distressed one. Regulators therefore need to find other ways of persuading high-quality management teams to take on failing hospitals, including giving them the time, space and resources to succeed.

Similarly, it is far from clear that NHS providers need to pursue mergers to achieve many of the other benefits identified in their business cases, such as sharing best practice, achieving scale in clinical services or reducing procurement or back-office costs. In other industries, it is increasingly unusual to pursue large mergers to secure relatively small benefits in these areas. As in other sectors, NHS organisations need

Table 3 Alternative strategies for challenged providers

Possible reasons for financial failure	Possible underlying causes	Possible remedies	Arguments for merger
Insufficient funding to deliver required services	• Limitations of current payment systems including tariffs and block contracts • Historic arrangements that provide insufficient funding for particular services • Poor understanding of costs of delivering services efficiently to necessary quality levels • Inadequate resourcing for some commissioners and their populations • Failure by commissioners to make difficult decisions on how to allocate limited resources	• Reform payments to better reflect efficient providers' costs • Agree top-up income for providers with unavoidably higher costs • Make more effective decisions on how best to target limited resources • Modify allocations to commissioners if needed to reflect population needs	None. There should be no need for providers to merge to renegotiate funding for services
Poor capital structure (eg, insufficient working capital or high debt burden)	• Accumulation of high levels of debt, for example where debt has been used to cover deficits rather than improve productivity • Limited scope to write down debts, convert debt to equity or otherwise recapitalise outside merger	• Develop financing regime to offer appropriate financing packages to failing providers, without the need for a merger	None. There should be no need for mergers simply to address the capital structure of a provider
Weak leadership, management or governance	• Poor initial selection of the senior leadership team • Regulatory intervention that deters good leaders or undermines stable leadership • Unattractive packages to persuade high quality teams to take on failing trusts • Absence of other factors that good teams would require to take on failing trusts (e.g. the necessary financing packages to turn them around) • Insufficient internal leadership development and succession planning	• Replace poor management with a strong, stable, leadership team, if there are compelling reasons to justify this • Develop more attractive packages to bring high-quality permanent management teams into struggling providers • Address other underlying reasons for failure such as the need to recapitalise the organisation or invest in transformation • Invest in succession planning	Very few. It seems disproportionate to assume the costs and difficulties of merger to replace leadership. Mergers can themselves weaken leadership as they act as a significant distraction for the senior team
Inefficient operations	• Poor leadership or management leading to failures to improve productivity • Effective opposition among stakeholders to the necessary productivity improvements • Absence of appropriate skills and capabilities in service improvement or leading change • Difficulties securing investment to support service improvement	• As above, develop strategies to establish strong, stable leadership where needed • Provide financing packages to support service improvement where needed • Develop skills and invest in making the case for and leading transformation	Very few. There is little evidence that mergers make it easier to deliver service improvement. There are many routes for introducing effective models that do not entail the costs and difficulties of merger
Lack of efficient scale	• Impact of external factors such as competition or new technologies on demand for services	• Use partnerships, franchises or outsourcing to achieve scale in discrete areas	Few. Merger provides one route for achieving scale.

Table 3 cont'd

Possible reasons for financial failure	Possible underlying causes	Possible remedies	Arguments for merger
Lack of efficient scale (cont'd)	• Regulation that prevents trusts exiting services when they cannot achieve sufficient volumes • Public, political or internal opposition to closures or restructuring to achieve minimum scale	• Close services on under-used sites where alternative services are available • Provide additional revenue funding if providers need to continue to offer the services but have unavoidably higher costs	But partnerships, franchising and outsourcing can often do so with less disruption, risk or cost.
Poor alignment of services in the local health system	• Poor system leadership to improve co-ordination of services across local providers • Regulatory rules or payment systems that discourage effective cross-system collaboration • Contractual arrangements that hinder effective integration across sectors • Inappropriate configuration or under-development of particular sectors in the local system • Difficulties securing investment to support whole system transformation	• Invest in system leadership to build common purpose and shared goals • Remove regulatory barriers to effective co-operation across systems • Introduce pooled budgets and cross-system governance where needed • Provide funding packages to support whole system change without need for merger	Unclear. Merger provides one route for co-ordinating and aligning services. However, there are many international examples of virtual integration through partnership or contracts to achieve the same objectives
Outdated infrastructure	• Poor historic decisions or changes leading to inappropriate infrastructure • Sustained under-investment in hospital facilities in some providers • Features of the financing regime that make it hard for some providers to make capital investments	• Provide capital to address under-investment in infrastructure without the need for mergers	None. There should be no need for mergers simply to provide capital for facilities or infrastructure
Inflated input costs	• Growing demand and under-supply of resources such as staff in particular specialisms • Ineffective strategies to ensure sufficient supply of inputs such as training and development of staff • Failure by providers to redesign roles or make other changes to respond to these conditions • Restrictive regulation or guidance on staffing levels, roles or how services are delivered	• Invest in redesigning roles and processes to reduce reliance on scarce inputs • Address barriers preventing providers substituting to lower cost alternatives • Address shortcomings in forecasting and managing the supply of scarce inputs	Few. There is little evidence that mergers make it easier to recruit staff. It should be possible to redesign roles within individual organisations or through partnerships where needed
Excessive size and complexity	• Diseconomies of scale, scope or complexity from bringing incongruous services under one roof	• Acquire particular services or transfer services to other providers to develop more coherent service groupings • Separate different services in distinct business units where needed	Few. Mergers between large hospitals are likely to create further complexity rather than remedying it. However, there

Table 3 cont'd

Possible reasons for financial failure	Possible underlying causes	Possible remedies	Arguments for merger
Excessive size and complexity (cont'd)			might be a role for vertical mergers or transfers of individual services between providers to develop more coherent organisations
High operating costs due to historic investment decisions	• Ill-considered historic investment decisions • Unforeseen changes in demand for services or the infrastructure needed to deliver them • Inability or unwillingness to switch infrastructure to other more profitable uses	• Develop strategies to switch infrastructure to more profitable uses where possible • Partnerships to make better use of facilities • Provide ongoing revenue support to cover additional costs where needed	Few. A merger cannot remedy past investment decisions. Providers can reach agreements to make better use of assets without the need for mergers

to explore a range of less risky and disruptive options for securing scale in particular activities where needed, including through partnerships, joint ventures, outsourcing and franchising.

One of the questions raised by this paper is whether mergers make it easier or harder to accomplish major service reconfiguration. On the one hand, they might buy leaders of challenged providers a little more time – 'putting an umbrella over a struggling provider' – or make it slightly easier to present reconfiguration to the public. In theory, mergers that bring services within common ownership might reduce the bargaining costs of reaching agreement on reconfiguration or closures.

On the other hand, mergers might act as a substantial distraction from the challenges of reshaping services. At worst, some evidence suggests that mergers allow poorly configured or inefficient services to survive within larger organisations, making it easier to defer difficult changes to how they are delivered (Weil 2000; Bogue *et al* 1995).

Our review, like other research, suggests that major mergers are more likely to act as a barrier to, than an enabler of, transformation. In some of our examples, providers spent four to five years identifying a merger partner, developing the business case and gaining approval. While public attention is often focused on the financial costs

of major projects, the demands on senior leaders' time and the diversion of attention from service improvement could be more significant. Where reconfiguration is needed, the NHS should focus leadership time and funds on developing the service model, building the evidence base, engaging clinicians and other staff, winning over the public and managing an effective implementation process, rather than spending those resources on transactions.

One alternative approach, outlined in a future paper (Ham and Alderwick, forthcoming), is for groups of NHS providers, local authority services and other partners to work together to develop place-based systems of care, cutting across existing organisational and service boundaries to meet the needs of a defined local population. Such an approach would build on the principles of 'whole-system intervention' identified in the national bodies' new 'success regime'.

Under this approach, groups of organisations would work together to ensure the financial and clinical sustainability of services across the local system – rather than adopting a fortress mentality where individual organisations or neighbouring hospitals seek to secure their own sustainability irrespective of the impact on other services. We have described elsewhere how these types of integrated models might evolve into population health systems where NHS organisations, local authorities and other partners work together to deliver shared objectives for population health improvement (Alderwick *et al* 2015).

Such an approach depends on local partners reaching agreement on a common set of objectives that reflect the needs of their local populations, and establishing robust governance arrangements that balance organisational autonomy and accountability with a commitment to partnership working and shared sovereignty. In many cases, there will also need to be substantial redesign of performance measurement and payment systems, such as capitated budgets linked to the delivery of agreed outcomes across the system of care.

These emerging collaborations look very different to the horizontal mergers of neighbouring hospitals discussed in this paper, typically bringing together a much broader range of partners across health and social care. In some cases, there might be arguments for vertical mergers, for example involving primary, community and acute services, to create integrated systems. However, there are many international examples of virtual integration to create integrated systems through partnerships

or contracts. At present, it is hard to tell whether structural integration through common ownership offers substantial advantages over virtual integration through robust partnerships.

Given the findings of this review and the broader body of evidence on the impact of mergers, we make the following recommendations.

- While mergers will continue to play a role in the NHS, the national bodies should rule out mergers as a route for NHS trusts to gain foundation trust status or as a response to failure, in the absence of evidence that mergers typically help to create more sustainable organisations.

- Instead, regulators and providers should develop alternative strategies that target more effectively the root causes of failure, without the costs and distractions of mergers, even if this is more challenging in the short term.

- The national bodies should develop new strategies to attract high-quality management teams to take on challenged trusts without the need for mergers, including giving them the time, space and resources to succeed.

- The Department of Health should fill gaps in the financing system so that providers do not need to pursue mergers simply to recapitalise a failed trust or secure appropriate funding packages for turnaround or reconfiguration.

- As an alternative to mergers, the national bodies and providers should explore scope to develop place-based systems of care, with the emphasis on collaboration across organisational and service boundaries to meet the needs of a defined population while ensuring financial and clinical sustainability.

- Where solvent providers contemplate transactions, they should make a detailed, objective evaluation of alternative options and a realistic, evidence-based assessment of the costs and benefits of pursuing a merger.

- Where mergers are contemplated, providers should carry out a careful appraisal of the options for re-grouping services to create coherent organisations and business models, rather than simply merging neighbouring hospitals into more complex and unwieldy conglomerations.

- Monitor and the NHS Trust Development Authority should play the role of sceptical shareholders, carrying out a rigorous independent assessment of providers' merger plans at a stage when other options are still on the table.

- The government should ensure greater transparency in how public funds are used to support mergers and at least some ex-post evaluation of whether these investments deliver value for money.

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About the author

Ben Collins joined The King's Fund in 2015 as a project director, working for the Chief Executive and across the Fund, including on policy and supporting the NHS in developing new care models.

Before joining the Fund, Ben worked as a management consultant. He has advised central government and the national bodies on a wide range of issues including economic regulation, provider finance, the provider failure regime and new organisational models. He has also worked with a large number of NHS purchasers and providers on strategic and operational challenges.

Ben has an academic training in industrial economics and business strategy.

The King's Fund is an independent charity working to improve health and health care in England. We help to shape policy and practice through research and analysis; develop individuals, teams and organisations; promote understanding of the health and social care system; and bring people together to learn, share knowledge and debate. Our vision is that the best possible care is available to all.

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Mergers have reshaped the NHS since its creation and our enthusiasm for them shows no sign of abating. Significant sums of money are being spent on them. But why are mergers instigated and by whom, who is involved in assessing them, what are the costs involved and are mergers the best course of action?

Foundation trust and NHS trust mergers: 2010 to 2015 reviews 20 major mergers involving foundation trusts and NHS trusts from 2010 to mid-2015. It draws on interviews with senior system leaders, published information on the mergers and reports from regulators, special administrators and the competition authorities. It looks at the strategic rationale for the mergers, the approval process and the financing packages provided to complete them.

The report shows that:

- in the period under study, almost all of the mergers were initiated by regulators or administrators, with the aim of either helping NHS trusts to gain foundation trust status or rescuing providers from financial challenges

- there are serious weaknesses in organisations' articulation of the case for merger and in their assessment of alternative options.

- very large amounts of money are being spent on such mergers – for example, £2 billion was spent on just 12 mergers during this period

- it is unclear whether mergers are likely to address the root causes of providers' difficulties in many cases.

Our review sits alongside other research from health care and other industries that shows mergers typically fail to deliver the intended benefits. While mergers will continue to play a role in the NHS, the report concludes that the Department of Health, Monitor and the NHS Trust Development Authority should rule out mergers as a way for NHS trusts to gain foundation trust status or as a response to failure, focusing instead on supporting actual service improvement and system-wide transformation.

Where providers contemplate transactions, we need to ensure a higher standard of strategic thinking on alternative options and a realistic assessment of the costs and benefits of merger. Monitor and the NHS Trust Development Authority need to play the role of sceptical shareholders, providing objective oversight and challenge.