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NHS CONFEDERATION

The triumph of hope over experience

Lessons from the history of reorganisation

By Nigel Edwards

The voice of NHS leadership

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Introduction

Restructuring has been a common occurrence in the NHS over the last 20 years, including mergers and reorganisation, the abolition and creation of new organisations and renaming and reforming of others.

With the coalition Government now in place and the scale of the financial challenge facing the NHS over the next three to five years, calls for large-scale reorganisation are increasingly likely.

This report is part of a series from the NHS Confederation reflecting on the last decade of NHS reforms to help managers, policy-makers and politicians ensure that some of the errors made in the past are not repeated. It aims to inform these debates and decisions, and is intended to generate discussion rather than present a definitive policy position.

We review the history of restructuring, what is known about its results and the reasons for the pattern of increasingly frequent organisational change to draw out some important lessons that are particularly salient at this time.

The evidence outside healthcare shows that no more than 25 to 30 per cent of mergers and acquisitions in the commercial sector succeed. Given the greater complexity and level of risk in the NHS, this success rate would be optimistic.

While modest savings can be made over time, dysfunctional effects of reorganisation include a loss of focus on services, delays in service improvements and a difficulty in transferring good practice within the merged organisation.

There is too little analysis of what can be learnt from previous experience and yet this is essential if we are to meet the major efficiency savings required and deal with the changes to community services that are currently being considered.

Reorganisation has a number of meanings in health policy. In this paper we examine the evidence about changing the size, number and responsibilities of the organisations responsible for planning and delivering healthcare and some of the agencies responsible for regulating or supporting them.

We are primarily interested in administrative reorganisation rather than clinical changes and do not look specifically at reorganisations of administrative structures within stable organisations. However, many of our conclusions would also apply to all types of reorganisation.

The logic of ensuring that organisations are structured in the right way to deal with the challenges that they face is unassailable, but the scale of recent reorganisations goes beyond the level of reshaping required to allow organisations to adjust to changes in their environment.

There is good reason to suppose that restructuring will have some adverse effects, may fail to deliver the promised benefits and may be carried out in haste or with insufficient thought, leading to further reorganisations later.

Although there is widespread acknowledgement of the problems of frequent reorganisation, there is still a tendency for it to be enthusiastically advocated as a solution – often with little reference to the problem it is trying to solve.

We need to put proposals for restructures under closer scrutiny, learn from our mistakes and hold the proponents of reorganisation accountable for the results.

The pattern and impact of reorganisation

Reorganisation patterns

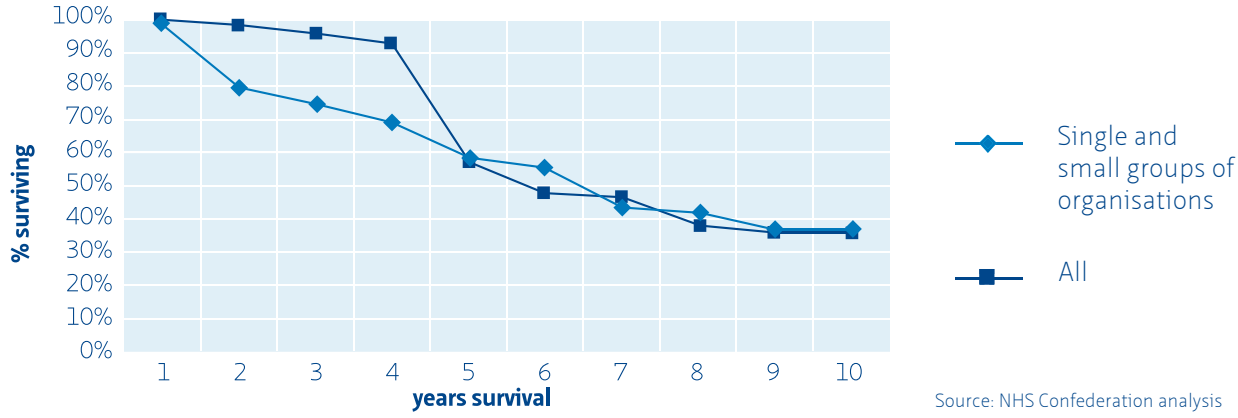
Some of the most significant organisational changes over the last two decades (see Annex A) share a number of striking features. Firstly, some types of organisation are subject to very frequent changes while others have been untouched for decades. Intermediate management structures such as health authorities, primary care trusts, regional offices, regulatory bodies, improvement agencies and leadership development have been subject to high levels of change.

Secondly, there are a number of organisations with very short lives – in the case of the National Care Standards Commission, the announcement of abolition came just 17 days after the official start date.

Significant levels of continuous change are also punctuated by major extinction events. Figure 1 shows the survival of all organisations where we have a start and end date: the line that excludes 'mass extinction' suggests that organisations that are not part of a larger group, such as primary care trusts, are more prone to an early demise, perhaps because they are easier to change.

Figure 2 shows the pattern of change in organisational numbers from 1998 for health authorities and trusts.

Figure 1. Safety in numbers: the probability of NHS organisations surviving (1990–2009)



Source: NHS Confederation analysis

Figure 2 Numbers of trusts and health authorities

	1998	1999	2000	2001	2002	2003	2006	2007	2008
(District) health authority	100	99	99	99	95				
PCT and care trust			40	161	304	304	152	151	151
Ambulance	35	35	32	32	31	31	12	11	12
Acute and specialist hospital	173	173	173	176	176	173	171	169	173
Mental health and learning disability	39	36	50	51	51	65	57	57	60
Community trust	113	107	99	64	17	14	12	11	11
Multi service trusts	65	65	32	27	18	8	7	6	6
Regional bodies	8	8	8	32	32	32	10	10	10
Total	**533**	**523**	**533**	**642**	**724**	**627**	**421**	**415**	**423**

Source: NHS Confederation analysis

It is notable that acute hospital trusts have been much more stable than other health bodies. Although there have been enormous changes in the commissioning levels of the NHS, the average population size covered is similar to that at the beginning of the period. A similar pattern is seen in regional bodies.

From 1948 to 1974 there was very little change in the institutional architecture of the NHS and relatively few organisations were created or abolished. From the mid 1980s onwards the pace of change has increased significantly.

The impact of reorganisation

The best evidence we have about the impact of reorganisation is from mergers, and this is far from encouraging. Outside healthcare, the evidence suggests that no more that 25 to 30 per cent of mergers and acquisitions succeed.[1] There is no reason to suppose that healthcare mergers have been any more successful, given the greater complexity and level of risk. The international evidence confirms this.[2] Of the 2,497 mergers of US organisations that occurred between 1999 and 2003, studies by Gaynor and Vogt show decreased competition and price increases of up to 53 per cent.[3]

Recent analyses of restructuring at a central government level have found that benefits from reorganisations are similarly hard to demonstrate.[4, 5] Changes to a Whitehall department or arms-length body typically lead to a significant dip in productivity and a two-year delay before any benefits are likely to accrue, by which time many of these organisations will have been reorganised again.

Fulop et al [6, 7] studied provider mergers in the NHS and found some positive effects in terms of staffing, training and influence on the local healthcare system. There was some improvement in integration and the sharing of good practice among managers and clinicians. Modest savings from reduced management costs of up to £500,000 were achieved, but there were also a number of dysfunctional effects:

- loss of managerial focus on services, with risks to patient safety
- delays in service developments by at least 18 months
- staff felt that managers became 'remote'
- smaller trusts perceived a loss of informality and familiarity, as well as viewing their larger

counterpart as slow moving and unresponsive

- other than management cost savings, which were below the level hoped for, no savings were evident from the mergers after two years
- difficulty in transferring good practice internally due to widespread distrust and staff still perceiving each other as part of the old constituent trusts.

In short, mergers are frequently associated with persistent poor performance and often do not realise the benefits or financial savings they promise.[6, 7, 8] Frequent organisational change has often led to a loss of momentum, some significant risks of harm to staff[9] and risks of creating cynicism, particularly among clinicians. In its investigations into serious quality and safety lapses at Stoke Mandeville and Maidstone hospitals, the Healthcare Commission highlighted poor integration following large-scale mergers.[10, 11]

Other than mergers, restructuring has not been studied very extensively, despite the availability of case study material. But it is clear that this is not a unique problem for the UK. For example, Dwyer's analysis of Australia's experience of multiple reorganisations towards a more centralised health service (which may soon be reversed) showed no obvious patient benefit.[12] One important piece of anecdotal evidence is that the PCTs that were reorganised as part of *Commissioning a Patient-led NHS* performed significantly less well in the 2006/07 Annual Health Check than those that were not reorganised.[13]

Other effects of restructuring seem to include the dislocation of key external relationships. Where there is an expectation that there will be restructuring or merger, there is a powerful incentive not to collaborate or make compromises with potential competitors for posts in new organisations.

Why is there so much restructuring?

The reasons for the increase in the pace of restructuring since 1980 are not very clear, but it may be that structural change is one of the few big levers available to policy-makers who find it very difficult to intervene in the 'black box' of clinical decision-making. It may be associated with the growth in popularity of the 'new public management' philosophy which prompted interest in the use of market mechanisms, the outsourcing of delivery functions and a general trend for previously neglected parts of the public sector to become subject to more direct managerial control. Some of this has undoubtedly been beneficial and the increase in restructuring may be an unintended consequence of this change.[14] In addition, there are also strong incentives for policy-makers and managers to drive restructuring.

Ministers and the Department of Health have initiated some of the largest-scale changes, sometimes associated with the periodic need to be seen to be 'bearing down on bureaucracy'. Performing a vital function that should not be disrupted is not a particularly successful defence against structural change. Being small, in a niche or obscure is more helpful, for example the Family Health Service Appeals Authority was untouched for many years.

A third reason for restructuring is the transfer of ideas from other parts of the public sector into the NHS, for example changes in regulation which have been borrowed from education.

For individual managers the incentives appear to be significantly biased in favour of restructuring. Losers in the process are often senior enough to benefit from generous severance and early retirement packages. Winners get to lead larger organisations and reap the rewards associated with this. Regional bodies have an incentive because mergers and restructuring have often been used as a reason for writing off large accumulated deficits.

Recent PCT reorganisations have been driven by the perceived lack of management capacity and the need to make the best use of scarce resources. This ignores the paradox that increasing size also increases complexity and means that there is still a shortage of talent. More broadly, economies of scope and scale are commonly cited as a reason for merger and consolidation. The evidence for these is sparse and there is little tracking to demonstrate whether the promised savings from this source have been achieved.

Coid and Davies suggest a number of non-financial incentives.[15] Reorganisation can be used to remove troublesome senior staff or non-executives. It also allows difficult decisions to be avoided and creates a highly visible, all-consuming activity which is a "potent demonstration of effective power" and a defence against allegations of inaction. This is particularly the case where merger or acquisition is used to deal with organisational failure. They argue that it serves to legitimise the work of senior management and quote Manfred Kets de Fries who suggests a range of psychological incentives for managers to restructure. These include a "retreat into action", which is a therapeutic response to what he sees are the frustrations, anxiety and depression that come from the realisation that the desire to control the system is unachievable. Similarly, McKinley and Scherer suggest that while organisational restructuring has the effect of producing cognitive order for senior leaders, it also contributes to long-term environmental turbulence. Both these feed back to create a further need for organisational restructuring.[16] This means that once a cycle of reorganisation has begun, the frequent failure to deliver prompts a further attempt to solve the problem with further restructuring.

Why does so much restructuring fail?

Many of the reasons given for why organisations need to be abolished or restructured relate to structural weaknesses or an apparent lack of fitness for purpose. The short life of many of these organisations suggests these problems were part of their original design.

Lack of clarity of purpose

A number of cases of rapid restructuring have shown insufficient clarity about what the organisation was expected to do, what it was for and the basics of who the main customer was. In the case of the NHS University (NHSU), Sir Williams Wells' review found that, even some time after its formation, it was unclear whether the organisation was a commissioner, provider, broker or a national-level agency responsible for analysing educational needs.[17] This lack of clarity persisted and two years after its formation Wells reported that the Department of Health strategy board had not managed to address some of the key questions about the NHSU's purpose or resolve important overlapping functions with other organisations. This problem seems to have been exacerbated by a degree of over-ambitious positioning.

Lack of a clear purpose was also a problem for the Modernisation Agency (MA). The customers for its work were, de facto, provider organisations and front-line staff but its agenda was set by the Department of Health, whose preference was for change by direction and coercion rather than the MA's more facilitative approach based on skills and knowledge development. A number of other factors introduced further confusion. Firstly, it was created from three programmes that had quite different purposes. Secondly, civil servants who had programmes that they wanted to promote saw the MA as a delivery agency and a vehicle by which they could channel funding into direct implementation rather than risking devolving money to front-line organisations who might apply it in other ways. This led to the agency being asked to take on an increasingly large, diverse, overlapping and eventually incoherent portfolio of work. Thirdly, the MA was given performance management responsibility for access targets and became partially co-opted into the delivery function of the Department of Health. Development and direct performance management did not fit well together and caused confusion for its users, funders and its own staff.

Confusion about clarity of purpose can arise because of a problem with organisational memory resulting from the turnover of ministers and officials. This is a particular feature of those organisations that are set up in response to an urgent problem that is a priority for a limited time, after which the reasons for the organisation's creation may fade. This is not necessarily a fatal problem but it does make the organisation more vulnerable to predation, challenge or abolition in one of the periodic culls of organisations just before and after general elections. Organisations set up as a result of a ministerial initiative might be expected to be more robust but because they are often set up in response to the minister's own agenda, it cannot be assumed that their successors will have any commitment to them or understand the reasons for their creation.

Poor organisational design

A number of examples of poor organisational design produce the need for future reorganisation.

For example, poor planning and development of the organisation can ensure that further reorganisation will be required relatively soon. Geoffrey Rivett comments that the way responsibilities were reallocated and the absence of clear guidance during the abolition of health authorities and the formation of strategic health authorities and PCTs in 2002 gave an impression of "making things up as one went along."[18] Discussion with a senior person involved confirms that this judgement is correct.

This was the result of senior politicians being involved in the detail of organisational design and the compromises and deals that were made, such as the decision to retain four regional offices (directorates of health and social care). The politicians were not really committed to this solution, which may explain why it rapidly unravelled and led to further reorganisations after 18 months and again four years later. Poor planning also appears to have been a problem with the NHS University and the overly hasty design of the Commission for Patient and Public Involvement in Healthcare and associated public and patient involvement systems. These plans were developed very quickly as a result of a ministerial determination to abolish community health councils, and the failure to spend time designing a functioning model to replace it was widely criticised at the time.

A lack of coherence in the organisation creates questions about its design and can have a negative effect on performance. The practice of merging hospitals that have very different cultures, or no shared geography, sense of place or even connecting roads, is a curiously common occurrence and seems to cause long-term problems of performance. Discussion is ongoing about the way that some arms-length bodies appear to have an uneasy mix of functions. This is the direct result of a previous ministerial decision to reduce the number of these bodies by an arbitrary number chosen before any analysis of their scope and role.

Most obviously, poor, over-complex or 'one-size-fits-all' approaches – such as the multiple layers of the 1974 reorganisation – set up systems that seemed destined to fail.

Weak culture and internal strife

A weak culture, incomplete integration following a merger and internal strife all appear to be implicated in organisational failure and therefore subsequent further restructuring. For example, some of the MA's individual fiefdoms resisted incorporation into the whole, failing to find ways to integrate and work coherently with the rest of the organisation and in some cases undermining its effectiveness.[19]

An illusory search for the best fit

After 1997, 99 health authorities were split into a large number of primary care groups and then primary care trusts because it was thought that they were too large to relate to primary care. The 302 PCTs were then reduced to 152 (fewer in reality because a number had shared management structures). One reason given for this was that the small groups had high overheads and did not map closely enough to local government boundaries. There were also questions about whether there were enough high-calibre managers to staff 302 organisations. Discussion is ongoing about a need for further amalgamation because it is now thought that many are too small to effectively commission from large acute providers, at which point, once again, they will lose co-terminosity with local government and contact with primary care. Research by Bojke et al in 2002 established that there is no ideal size for all the different functions of PCTs but the search goes on for an unattainable 'right' answer.[20] Regional tiers have been through a similar process with 14, eight, four, 28 and ten organisations over the last 15 years. And London has had one, two, four, five and six in the last 20 years. The way that procurement is organised also seems subject to similar cycles of regionalisation/centralisation, devolution, outsourcing and redesign.

Dealing with relationship issues through structural change

Problems of organisational boundaries, coordination and planning are often a driver for restructuring. The advocates for structural change make bold claims for its impact on problems of coordination and inter-organisational boundaries. However, structural change should be the last step in the process

of service integration, after process and cultural barriers have been addressed. For example, a study by King et al showed that some children's services had significant internal boundaries in integrated organisations greater than those between organisations.[21] Braithwaite et al argue that restructuring tends to ignore the difficulty of shifting the values, norms and assumptions, meaning that it is unlikely to achieve the necessary integration at this level. A number of studies by Shortell, Denis and others re-enforce the importance of culture, values, processes and systems over structure.[22] The general neglect of these makes failure and reorganisation more likely.

The environment

Predators

Reorganisation sometimes seems to come about through lobbying and predatory activities by other organisations that have an interest in acquiring additional resources. Functions such as leadership development, training and workforce commissioning have large budgets and a number of organisations can claim to have the skills or be appropriately positioned to take these on. This seems to partly explain the fate of the MA and Workforce Development Confederation, both of which had large budgets and seemed to be on the turf of rival organisations.

Conversely, organisations such as the Public Health Laboratory Service, the National Institute for Health and Clinical Excellence (NICE) or the Human Fertilisation and Embryology Authority (HFEA) that have highly complex and technical functions and in some cases quite high levels of risk, offer few financial or other rewards to the potential asset stripper. As a result, they seem much less prone to predatory activity or restructuring.

Some organisations have been established in the teeth of powerful opposition. For example, the entire higher education sector, including the then Department for Education and Science, was deeply unhappy about NHS University's ambitions to be a full university. Similarly, the medical establishment was very much opposed to the creation and constitution of the Postgraduate Medical Education and Training Board[23] and the Commission for Patient and Public Involvement in Health inherited a great deal of residual resentment from those angry at the abolition of community health councils and converted this into general hostility through the way it conducted its business. This type of opposition is difficult to overcome. NICE has managed to survive a sustained assault from some patient groups and the pharmaceutical industry but has shown a great deal of skill at navigating this, much more than many now defunct organisations. It also seems to have had more significant political support because of its role in creating a fire wall between ministers and difficult decisions.

Limited learning

It is difficult to identify the lessons that might be drawn from structural change as there is usually no measurement of a baseline and little or no evaluation. This may be because of a lack of a culture of evaluation, a genuine problem in designing studies in such a complex area and perhaps because there is a risk it may reveal that the policy was not a success. In the past, ministers and special advisers have reacted badly to evaluations that failed to support their policies.

Even if there had been a more systematic evaluation, the number of changes in the last two decades means that many structures have had little time to settle down and produce results before being reorganised.

Perhaps the most significant reason for a lack of learning is the absence of a well-developed theory of organisational success or failure. Braithwaite et al argue that the approach to restructuring is based on a formal, hierarchical and mechanistic view of how organisations work.[24] This downplays the importance of culture, norms, values and relationships. It also fails to understand the complexity of issues and therefore will fail to predict many of the potential unintended outcomes.

Conclusions

It is important to emphasise that reorganisation does not always fail and there are examples of success where reorganisation has allowed changes in performance. The challenges that health services have to deal with are always subject to change and some degree of flexibility is required. However, as this paper suggests, reorganisation often seems to be pursued in the absence of good evidence.

The restructuring research

The research agenda is obviously closely aligned with these policy questions but there are some interesting additional issues:

1. Does organisational complexity tend to grow faster than organisational size? This would mean that the amalgamation of organisations to make the best use of talent might be self defeating.

2. Does Gresham's Law apply to organisational culture: does the bad corrupt the good?

3. What conclusions might be drawn about the processes described here if viewed through different perspectives – anthropology, discourse analysis, etc?

Overall, the history of restructuring and merger is not encouraging and yet the enthusiasm for it continues. This contrast illustrates some important problems with management and policy-making in the NHS. Firstly, there is too little analysis of what can be learnt from previous experience, partly because there is little evaluation. Secondly, the incentives in the system seem to encourage it and many of those who were confident advocates of one reorganisation move on to support the next one with little trace of embarrassment. Thirdly, too often we resort to universal solutions and big bang reorganisations rather than careful experiment or local design, and we do not tolerate variation in size and scope. This leads to a lack of attention to issues of detail, geography and other contingencies which should be considered in organisational design. This is particularly true when considering the impact of different organisational culture between merged organisations. Fourthly, there seems to be a tendency to adopt new ideas without critical appraisal. And, finally, there is an absence of a useful theory underpinning the practice of management, organisational design and policy formation that could otherwise provide a way of using the learning, designing organisations and predicting the outcome of reorganisation.

So, the policy conclusions are:

1. Be very cautious about the motives of those proposing reorganisation; make sure that the suggested solution actually matches the problem and is based on some evidence.

2. Proposals to create, merge or otherwise restructure require much more scrutiny and challenge, particularly where apparently arbitrary numerical targets are advocated. In general, the claims made will prove to be over optimistic. Better scrutiny of decision-making processes and insistence on proper business cases is required (without creating an industry of document production designed to transfer risk between organisations).

3. Poorly designed organisations and hasty change are likely to result in further restructuring.

4. Mergers may be helpful for facilitating major service rationalisation between sites. However, the evidence of scale advantages is sparse and the relatively poor performance of some of the very large organisations

created in this way suggests that these are over stated.[25] It seems likely that the marginal costs of additional complexity may increase more rapidly than any advantages from increased scope and scale.[26]

5. The idea that reducing the number of organisations is a way of dealing with a shortage of talent seems doubtful. Creating fewer, more complex organisations may mean that the demands of the new posts rule out many of those considered talented enough to deal with the current challenge.

6. More opportunities are needed to hold the proponents of reorganisation to account for the results.

7. Better evaluation of the results is necessary to ensure learning. Before and after studies need to be commissioned before change happens.

8. Organisational change is necessary to allow organisations to adapt to changes in the environment. Experiment and evolution may be a more effective approach to this than insufficiently intelligent design.

This paper is intended to generate discussion rather than present a definitive policy position. We are keen to publish reader viewpoints on our website. Please email your ideas and comments to nigel.edwards@nhsconfed.org

References

1 A detailed table of major organisational changes can be found in the PDF version of this report, available at www.nhsconfed.org.

2 Field J, Peck E (2003) 'Mergers and acquisitions in the private sector: what are the lessons for health and social services?' *Social Policy and Administration*, 37, 7.

3 Braithwaite J, Westbrook J, Iedema R (2005) 'Restructuring as gratification', *JSRM*, 98, pp 542–4.

4 Gaynor M, Vogt W (2003) 'Competition among hospitals', *RAND J Economics*, 34, pp764–85.

5 National Audit Office (2003), *Reorganising central government*.

6 Institute for Government (May 2010), *Making and breaking Whitehall departments*.

7 Fulop N, Protopsaltis G, Hutchings A, et al (2002) 'Process and impact of mergers of NHS trusts: multicentre case study and management cost analysis', *BMJ*, 325, pp246–9.

8 Fulop N, Protopsaltis G, King A, Allen P, Hutchings A, Normand C (2005) 'Changing organisations: a study of the context and processes of mergers of health care providers in England', *Soc Sci Med*, 60, pp119–30.

9 Goldman M (2010) 'Out of the mud and back on track', *Health Service Journal*, 6 May 2010.

10 Coid D, Davies H (2007) 'Healthcare workers' wellbeing and the therapeutic relationship: does organisational change do damage?' *Public Money and Management*, April 2007.

11 Healthcare Commission (July 2006), *Investigation into outbreaks of Clostridium difficile at Stoke Mandeville Hospital, Buckinghamshire Hospitals NHS Trust*.

12 Healthcare Commission (October 2007), *Investigation into outbreaks of Clostridium difficile at Maidstone and Tunbridge Wells NHS Trust* (page 112).

13 Dwyer J (2004) Australian health system restructuring – what problem is being solved?' *Aust NZ Health Policy*, 1, doi:10.1186/1743-3462-1-6

14 www.cqc.org.uk/_db/_documents/Annual_health_check_national_overview_2006-2007.pdf

15 Osborne D, Gaebler T (1993) *Reinventing government*. Plume.

16 Coid DR, Davies H (2008) 'Structural change in health care: what's the attraction?' *J R Soc Med*, 101, pp278–81.

17 McKinley W, Scherer AG (2002) 'Some unanticipated consequences of organization restructuring', *Academy of Management Review*, 25 (4), pp735–52

18 Wells W (2004) *Review of NHSU*. Department of Health.

19 www.nhshistory.net/chapter_6.tml#Devolution_Day

20 Bate P, Robert G (2006) *Lessons from the Modernisation Agency story*. Unpublished research report.

21 Bojke C, Gravelle H, Wilkin H (2001) 'Is bigger better for primary care groups and trusts?' BMJ, 322, pp599–602. See also www.npcrdc.ac.uk/Publications/isbiggerbetter.pdf

22 King A, Fulop N, Edwards N, Street A (2001) 'The interface of acute and community services in British health care providers: integration versus co-operation?' in Ashburner L, *Organisational behaviour in health care: reflections on the future*. Palgrave.

23 Ramsay A, Fulop N, Edwards N (2009) 'The evidence base for vertical integration in healthcare', *Journal of Integrated Care*, 147 (12), pp3–12.

24 Hawkes N (2007) 'How not to win friends and influence people', *BMJ*, 335, p284.

25 Braithwaite J, Westbrook J, Iedema R (2005) 'Restructuring as gratification', *JSRM*, 98, pp 542–4.

26 Goddard M, Ferguson B (1997) *Mergers in the NHS: made in heaven or marriages of convenience?* Nuffield.

27 Christensen CM, Grossman JH, Hwang J (2009) *The Innovator's prescription: a disruptive solution for health care*. McGraw-Hill.

Annex A. Major organisational changes

Created	Abolished	Number	Organisation	Taken over by
1974	1994	14	Regional health authorities (RHAs)	
1984	1996	192 105	District health authorities	Health authorities
1985	1996	90	Family Health Services Authority	Health authorities
1994	1996	8	8 RHAs	Regional offices
1996	2001	8	Regional offices	Directorates of health and social care
1996	2001	99	Health authorities	SHAx28 PCT 303
1991 on	2001	6 113	Community trusts	
2001 on		12	Care trusts	
2001	2006	303	Primary care trusts	
2001	2003	4	Directorate of Health & Social Care	
2001	2004	24	Workforce development confederations x 24	SHAx28
2002	2006	28	Strategic Health Authorities x28	SHAx10
2006		152	Primary care trusts	
2006		10	Strategic health authorities x10	
2003	2005	1	NHS University	
2005	2010	1	Postgraduate Medical Education and Training Board (PMETB)	GMC
1987	2000	1	Health Education Authority	HD Agency
2000	2005	1	Health Development Agency	NICE
1946	2003	1	Public Health Laboratory Service	HPA
1970	2005	1	National Radiological Protection Board	HPA
1975	2009	1	National Biological Standards Board	HPA
2001		1	National Treatment Agency for Substance Misuse	
2003		1	Health Protection Agency (HPA)	
1998	2001	1	National Patient Access Tem (NPAT)	MA
2001	2004	1	Modernisation Agency	MA downsized version
2002	2005	1	NatPACT	
2002	2005	1	National Institute for Mental Health (NIMH)	CSIP
2004	2005	1	Modernisation Agency downsized version	NHSIII
2005	2009	1	Care Service Improvement Partnership (CSIP)	

2005		1	NHS Institute for Innovation and Improvement (NHSIII)	
1983	1990	1	National Training Authority	NHSTD
1990	2001	1	National Training Directorate	Leadership Centre
2001	2005	1	Leadership Centre	NHSIII
1974	2003	199	Community health councils (CHCs)	
2003	2008	1	Commission for Patient and Public Involvement in Health	
2003	2008	1	Patients forums	
1991	2000	1	NHS Supplies	PASA
1994	2005	1	Medical Devices Agency	MHRA
2000	2006	1	NHS Logistics Authority	Business Services Authority
2000	2009	1	Purchasing and Supplies Agency (PASA)	
2003		1	Medicines and Healthcare products Regulatory Agency (MHRA)	
1977	2005	1	Family Health Services Appeal Authority	
1983	2009	1	Mental Health Act Commission	CQC
1991		1	Human Fertilisation and Embryology Authority	May have survived an attempt to merge it with a new regulator
1999	2004	1	Commission for Health Improvement (CHI)	Commission for Healthcare Audit and Inspection
1999		1	National Institute for Clinical Excellence (NICE) Later National Institute for Clinical Excellence and Health	
2001		1	National Patient Safety Agency (NPSA)	
2001	2005	1	National Clinical Assessment Authority	NPSA
2002	2004	1	National Care Standards Commission	CSCI
2003		1	Council for the Regulation of Health Care Professionals (The Council for Healthcare Regulatory Excellence)	
2004	2009	1	Commission for Social Care Inspection (CSCI)	Care Quality Commission (CQC)

2004	2009	1	Commission for Healthcare Audit and Inspection (Healthcare Commission)	CQC
2004		1	Monitor	
2005	2009	1	Human Tissue Authority	Regulatory Authority for Tissue and Embryos
2009		1	Regulatory Authority for Tissue and Embryos	
1946	1991	1	National Blood Transfusion Service	National Blood Service
1991	2000	1	UK Transplant Support Service Authority	UK Transplant
1991	2005	1	National Blood Service	NHS Blood and Transplant
1991	2005	1	NHS Estates	
1995		1	NHS Litigation Authority	
1998	2006	1	NHS Counter Fraud and Security Management Service	Business Services Authority
1999	2005	1	NHS Information Authority	NPfIT
2000	2005	1	UK Transplant	NHS Blood and Transplant
2001		1	Appointments commission	
2004		1	NHS Professionals	
2005		1	NHS Blood and Transplant	
2005		1	Health and Social Care Information Centre	
2007		1	NHS Business Services Authority (BSA)	
1974	2007	1	Prescription Pricing Authority	Business Services Authority

The triumph of hope over experience

Reorganising and restructuring have been common activities in the NHS over the last 20 years and are again on the agenda with the coalition Government in place and the scale of the financial challenge apparent. Some savings can undoubtedly be made from restructuring or merging management, back office and front line functions, but the inevitable loss of focus on delivery and delays in service improvements are hard to ignore.

Analysing the learning from previous experience is essential if we are to meet the major efficiency savings required and deal with the proposed changes to community services.

This report looks at the available evidence about the pattern of reorganisation, why there's so much of it and why it often fails, and outlines the important points to consider when reorganising services.

Rather than setting out a definitive policy position, the report is intended to generate discussion. Please email your ideas to nigel.edwards@nhsconfed.org

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