

# **Organisational culture and post-merger integration in an academic health centre: a qualitative study**

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## **Abstract**

**Background:** Around the world, the last two decades have been characterised by an increase in the numbers of mergers between healthcare providers, including some of the most prestigious university hospitals and academic health centres. However, many mergers fail to bring the anticipated benefits, and successful post-merger integration in university hospitals and academic health centres is even harder to achieve. An increasing body of literature suggests that organisational culture affects the success of post-merger integration and academic-clinical collaboration.

**Methods:** This paper reports qualitative findings from a mixed-methods study to examine 1) the perceived differences in the pre-merger organisational culture of academic and clinical enterprises at two merging National Health Service (NHS) trusts in England, and 2) the major cultural issues for their post-merger integration and strategic partnership with a university. From the entire population of 72 physician-scientists at one of the legacy trusts, 24 (33%) provided qualitative responses, which were followed up by semi-structured interviews with six physician-scientists, and a group discussion including five senior managers.

**Results:** The cultures of two legacy NHS trusts differed, and the cultures of the clinical enterprise at both legacy NHS trusts were primarily distinct from the academic enterprise. The merger was viewed as a necessity, but also one with some promise. The majority of respondents detailed a movement from rejection to resistance, to a gradual willingness to enter into merger. Major cultural issues are related to the relative size, influence, and history of the legacy NHS trusts, and the implications of these for respective identities, clinical services, and finances. Strategic partnership with a university served as an important

ameliorating consideration in reaching trust merger. However, some aspects of university entrepreneurial culture are incompatible with the NHS service delivery model and may create tension.

**Conclusions:** There are challenges in preserving a more desirable culture at one of the legacy NHS trusts, enhancing cultures in both legacy NHS trusts during their post-merger integration, and in aligning academic and clinical cultures following strategic partnership with a university. The seeds of success may be found in identifying and cultivating current best practice in the respective NHS trusts and in good will. Strong, fair leadership will be required both nationally and locally for the success of mergers and post-merger integration in university hospitals and academic health centres.

**Keywords:** Organisational culture, Competing Values Framework (CVF), post-merger integration, university hospital, academic health centre (AHC), academic-clinical collaboration, strategic partnership, research and innovation, teaching, patient care.

## Background

Around the world, the last two decades have been characterised by an increase in the numbers of mergers between healthcare providers, including some of the most prestigious university hospitals and academic health centres (AHCs)[1-4]. An AHC consists of an academic enterprise represented by a medical school and other health profession schools or programmes, and an owned or affiliated clinical enterprise represented by one or more hospitals or health systems. Most commonly, an AHC is not a single institution, but “a constellation of functions and organizations committed to improving the health of patients and populations through the integration of their roles in research, education, and patient care” [5]. Because of their unique tripartite roles, AHCs have been at the forefront of innovation and high-quality care in Northern America and continental Europe. In England, the government has also attempted to improve efficiency, innovation, and the quality of care in the NHS, *inter alia*, through the integration of health care providers and the promotion of NHS/University partnerships [6]. Recent government proposals to reconfigure the NHS [7] and accelerate innovation [8] suggest that in the coming years this trend will continue.

Theoretically, integration through merger can be successful because it is associated with beneficial synergetic impacts, reduced duplication of services, economies of scale and scope (especially management costs), and increased market power [9]. In practice, however, benefits of mergers are “often based on managers’ beliefs about the benefits” rather than evidence [10], and in reality many mergers fail [10-12]. An increasing body of literature suggests that organisational culture affects the success of post-merger integration in healthcare [10-17]. For example, extensive multicentre studies of mergers in the UK found

that cost savings from these mergers were minimal and that perceived differences in organisational culture form “a barrier to bringing organisations together” [10, 11]. A recent overview of hospital mergers in Europe and North America argued that “[a]lmost all consolidations fall short, since those in leadership positions lack the necessary understanding and appreciation of the differences in culture, values and goals of the existing facilities” [12]. Research outside healthcare also highlighted the role of cultural compatibility in successful post-merger integration and called for cultural due diligence [18-20]. In particular, KPMG showed on a global scale that 83% of corporate mergers and acquisitions fail to enhance shareholder value, but that they are 26% more likely to be successful if they focus on identifying and resolving cultural issues [21].

Successful post-merger integration in university hospitals and AHCs is even harder to achieve because universities and hospitals have to integrate their academic and clinical enterprises while maintaining their organisational independence. It is such a formidable challenge that some have argued “[t]o date, an example of a vibrant and successful merger of academic health centers remains to be found” [22]. There is growing literature to suggest that organisational culture plays an important role in inter-organisational collaboration and partnership [23-28]. An analysis of a failed merger in the US concluded that “[w]ithout an exhaustive and in-depth review of organizational culture, mores, values, and mission, perhaps [mergers in academic medicine] are, in fact, destined to be folly” [28]. Likewise, an analysis of successful mergers in the US argued that in all merging teaching hospitals the cultures of legacy organisation do not align and that “[t]he challenge is to understand the degree of gap and how best to manage it over the subsequent process” [17].

Although the role of organisational culture in post-merger integration and inter-organisational collaboration is widely recognised, little empirical evidence exists to help academic and clinical leaders identify differences in culture and resolve cultural issues early in post-merger integration. In this article, we report our findings from a study into organisational culture at two NHS trusts during their post-merger integration and strategic partnership with the University of Oxford. Many of our findings will be relevant to other university hospitals and AHCs contemplating an assessment of organisational culture as a means of assisting successful post-merger integration and academic-clinical collaboration. Our findings will also be relevant to national policy-makers seeking to reconfigure health services and accelerate innovation.

## **Methods**

### **Research setting**

This study was conducted at the former Nuffield Orthopaedic Centre NHS Trust (NOC) during the first three months of its post-merger integration with the former Oxford Radcliffe Hospitals NHS Trust (ORH). These two NHS trusts combined at the same time as they undertook a strategic partnership with the University of Oxford, thereby creating the Oxford University Hospitals NHS Trust (OUH).

The NOC was a £79m-turnover single-hospital organisation [29] providing orthopaedic and rheumatologic services on one site near to the Churchill Hospital. The ORH was a £636m-turnover multi-hospital organisation [30] providing a wide range of general and specialist services across three sites: the John Radcliffe Hospital and the Churchill Hospital in Oxford (a mile away from each other), and the Horton General Hospital in Banbury (twenty miles

away from Oxford). As a result of merger on 1<sup>st</sup> November, 2011, the NOC joined the OUH as one of its seven clinical services divisions – the Musculoskeletal and Rehabilitation Division – while retaining its name as a hospital. The arrangement is captured well in the new NHS trust’s slogan, “Four Hospitals, One Trust, One Vision.”

The merger integration was envisaged to “make a step change in quality, cost-effectiveness and the academic-clinical integration” as well as “help to ensure the organisations’ long-term financial stability and enhance the ability to achieve Foundation Trust status within three years in line with Government requirements” [31]. Improvements in the quality of care were planned to be achieved through the redesign of care pathways that crossed organisational boundaries. Improvements in cost-effectiveness were expected to come over time from reductions in duplicate activities. In particular, these improvements would be in corporate services in the short term, and from the optimised use of theatres and wards in the medium term [31]. In the long term, improvements would come from an increased number of tertiary referrals, international patients, clinical trials and research opportunities encouraged by the joint NHS/University brand [31].

Historically, clinical collaboration between the NOC and the ORH was limited, but they both had a strong tradition of academic-clinical collaboration with the University of Oxford. The NOC had built its reputation as the country’s leading orthopaedic hospital on its own and throughout its history remained fiercely independent, whereas the constituent hospitals of the ORH worked together with many other organisations in the local health economy. Most strikingly, between 1948 and 1974, all Oxford hospitals except the NOC formed a Teaching Hospital Group known as the United Oxford Hospitals [32]. Nevertheless, both the NOC and the ORH had a long tradition of academic-clinical collaboration with the University of

Oxford, and had a common benefactor. In the 1930s, Lord Nuffield's benefaction helped modernise the NOC and establish university clinical departments in the hospitals belonging to the ORH and the NOC [32, 33]. At the point of merger, ten university clinical departments were co-located and embedded within the ORH and one within the NOC; and University-employed clinical academics made a significant contribution to the provision of high-quality health services by both NHS trusts.

The Joint Working Agreement between the University and the merged NHS trusts also came into being on 1<sup>st</sup> November, 2011, effectively providing a formal institutional framework for one of Europe's largest and most research-intensive AHCs:

- The Agreement institutionalised a strategic partnership between the academic and clinical partners with a joint tripartite mission of patient care, education, and research.
- The partners established joint governance structures, including a Strategic Partnership Board and a Joint Executive Group with four specialist committees.
- The partners entered into a Trade Mark Licence, which paved the way for the joint NHS/University brand identity. The license governs the use of the University mark in the NHS trust name in relation to the supply of health services.
- In the run-up to the Agreement, the clinical (NHS) partners introduced a clinically-led management structure that aligned with university clinical departments and thus enhanced academic-clinical collaboration.
- The partners pooled their resources and co-located their clinical trials and research governance teams to create a Joint Research Office.

## Research design

The University of Oxford Clinical Trials and Research Governance Team reviewed the study, and it deemed that no further ethics committee clearance was necessary. An anonymous online survey was conducted in October-November 2011 among 72 academic physicians and scientists at the NOC. They constituted the entire population of academic physician-scientists jointly employed by the NOC NHS Trust (as it was then) and the University. Since these academic physicians were working in both organisations, it was thought they were in the best position to assess the pre-merger cultures of their academic and clinical enterprises.

The survey instrument was adapted from the US Veterans Affairs Administration All Employee Survey and included 14 organisational culture items grouped into four subscales corresponding to the four cultural archetypes of the Competing Values Framework (CVF) [34]. Among the many ways to measure organisational culture in health services research [35, 36], the CVF is the method used most frequently [34]. It distinguishes between two dimensions of an organisation's competing or opposite values/priorities: centralisation and control *versus* decentralisation and flexibility; as well as the internal environment and processes *versus* the external environment and relationships with outside stakeholders. The resulting quadrants of the framework represent four cultural archetypes (entrepreneurial, team, hierarchical, and rational), which are depicted in Figure 1 together with their major characteristics.

Besides the CVF instrument, the survey included four other items prompting respondents to identify their substantive employer (University or NHS Trust) and to provide any additional open-ended comments or thoughts on the major cultural issues for the NOC/ORH merger,

and its impact on academic-clinical integration. To preserve the anonymity of responses, the survey included a link to another online form, where respondents could submit their email address if they were willing to be approached for interview.

Semi-structured interviews were conducted with six self-selected academic physicians and scientists at the NOC in January 2012. Interviews were typically 90 minutes in length, and conducted in the interviewee's environs. They explored organisational culture through interviewee descriptions of their work and its position within their field, hospital, and academic-clinical collaboration; opinions as to the impetus for merger, its conduct and potential cultural, clinical and academic effects; experiences of academic-clinical collaboration; and opinions of the Joint Working Agreement. The interviews were digitally recorded, transcribed, anonymised, and analysed for emerging themes. The interviews and open-ended responses from the survey were then classified and analysed using the CVF and the emerging themes.

During the analytical stage of the study, one of the authors (JF), who is the former Chief Executive of the NOC, held a group discussion with four other former members of the NOC Executive Team to corroborate and explain the findings from the survey and interviews. Notes of the discussion were taken and incorporated in the qualitative analysis along the CVF and the emerging themes. The perceptions of academic physician-scientists and the insights from executives are presented to complement each other.

## Results

A total of 38 completed questionnaires (response rate=53%) were received. Because of the small sample size, we did not perform a comprehensive statistical analyses as in our previous research at the ORH [26] and instead concentrated on the analysis of qualitative responses. However, it is interesting to note the differences and similarities in the perception of organisational culture according to the quantitative data from this small sample at the NOC and previous research based on a large sample at the ORH [26] (Figure 2):

- staff at the NOC perceived that its clinical culture is more team-oriented and entrepreneurial than at the ORH;
- staff at both merging trusts perceived that the academic enterprise has a less hierarchical and more team-oriented, entrepreneurial, and rational culture than in the clinical enterprise;
- staff at both merging trusts perceived the current University culture and the future preferred NHS/University culture similarly.

Of the respondents, 24 (33%) elaborated on cultural items from the questionnaire or other issues of particular concern. These helped to shape the avenues of investigation in interview, and opinions expressed were in large part replicated – in greater detail – in interviews. We provide below our analyses of qualitative data with a selection of the most informative respondent and interviewee quotations to illustrate the range and depth of perspectives and to highlight major cultural issues and potential problems. We also present insights from the former NOC Executive Team to corroborate and explain the perceptions of academic physician-scientists.

### ***Entrepreneurial culture***

The NOC was perceived by its members to be more research-active and more entrepreneurial than the ORH. Those interviewed attributed this to the nature of their clinical area and the loyalty of patients with chronic conditions to the institution and its research ventures. Because of its smaller size the NOC was also perceived to be more flexible than the ORH, but there was a concern that in the merged organisation this would be lost:

- “The [merged] organisation is so complex that it becomes very difficult to change things. I am very concerned that NOC will get dumbed down and clinical enterprise and innovation lost.”
- “It’s just that you have to adapt yourself to be effective in a different organisational culture.”

However, in comparison with the University, the NOC was perceived as less flexible and entrepreneurial, mainly because the NHS in general was thought to be too risk-averse, over-regulated, and focused on finances and immediate clinical impact:

- “It is very difficult to find anyone prepared to be responsible for a change in practice [in the NHS]. Managers get kudos for organisational changes which are often not in anyone’s interest, but difficult to stop. There is often blind adherence to directives. University is a bit more flexible, especially on the HR front, allowing short term employment.”
- “It is critical that the metric of improving patient care be the main one used to drive innovation. It is not possible to complete every single regulatory dictate to the letter and still have time to produce research that improves patient care. ...The job of the regulation is not to provide a zero risk environment for patients but to balance it with innovation that may improve care.”

Those interviewed welcomed the Joint Working Agreement because it provides a formal institutional framework – and thereby important support – for current academic-clinical collaboration. Nevertheless, a major issue for respondents was to reconcile different priorities in academic and clinical innovation and service delivery. There was a clear recognition of the different roles and primary emphases of clinical and academic settings and the need to balance these:

- “University is intensely innovation focused and has to continue this to remain competitive. ORH is service delivery orientated and has to continue this to remain viable. What works for one will not always work for the other and there is some complete and unavoidable incompatibility between the goals of both organizations. These need to be identified and coping strategies put in place so that time is not wasted re-identifying the same clash in different formats.”
- “NHS pathway redesign may preclude easy data access to research subjects if increase same day admission, one stop shop, etc. Enabling research access may decrease the efficiencies that can be achieved on operational NHS delivery. Cultures of both organisations need to understand importance of symbiotic working.”

The NOC Executive Team stressed the importance of getting the right balance and understanding between a more entrepreneurial university culture and the constraints within which the NHS operates. Being a statutory public organisation governed through contracts with healthcare commissioners, any NHS trust has to deliver services that are required by commissioners in accordance with the health needs of the local population. An NHS trust cannot choose to focus on a particular group of patients or a particular condition because of its interest and research potential. Likewise, an NHS trust cannot prioritise the likelihood of innovation over the need to provide good standards of service and to comply

with various safety regulations. These constraints make some aspects of entrepreneurial culture incompatible with the NHS service delivery model, and the high levels of entrepreneurial culture observed in the University may not be attainable in the NHS setting.

### ***Team culture***

The NOC was perceived to have a more team-oriented culture than the ORH because it was a relatively small organisation, and staff had a shared vision and were proud of their organisation. A statement by one individual was echoed in all interviews: “The NOC is about excellence and quality in orthopaedics”. This clarity of vision gives insight into the strong identity and loyalty the NOC enjoys. Although respondents felt that the NOC needed better engagement with the ORH, they were concerned about the NOC losing its strong team values and being treated unequally:

- “Staff here [at the NOC] are hugely proud of their low infection rates, of hygiene, of MRSA, of service delivery and of finances. It has run as a very competent little place.”
- “[A major cultural issue for the NOC/ORH merger is] ensuring equality across the organisations, the NOC has traditionally been quite introverted and has had no real need to engage with the acute trust [ORH]. Both organisations will need to engage with the issues faced by both – musculoskeletal services are very different on the two sites, and have very different needs.”

The NOC Executive Team pointed out that history had influenced the identity and culture of the NOC, and that it still colours the views of some NOC members as to whether an integrated organisation can actually succeed. Traditionally, the individuals who were influential at the NOC felt that the only way the NOC could survive and achieve its objectives was to be separate. Although they are now long gone, their views carried forward for rather

a long time and could be seen, for instance, in the split of trauma and orthopaedics services between the two sites. The NOC was historically perceived by many in the local health economy as not just separate but isolated; an ivory tower, and not a team player. In turn, the ORH was historically perceived by many NOC members as the “big beast on the hill”: not well-managed and consuming all the attention and resources, as opposed to the “small and beautiful” NOC. NOC members have perceived the success of their organisation as being due to its separateness and have developed a strong shared vision around their clinical area. In the run-up to the merger, many NOC members were concerned that from being an organisation with a clear vision and purpose they would become just an orthopaedic department of an organisation that had a much wider goal. Yet, there was a recognition that to some extent a clear shared vision could be sustained by creating in the merged organisation a devolved organisational structure, where different divisions are encouraged to develop their own identity, vision, and culture.

Whereas the early instances of teamwork between NOC and ORH physicians are positive, experiences of teamwork with managers are mixed. Respondents in different clinical teams had different – sometimes diametrically opposite – experiences of working with managers at the other trust, with responses ranging from “very caring and supportive” to “demoralising”. Notwithstanding such marked differences in experiences, respondents would have preferred a more caring and supportive attitude from managers and more teamwork instead of focussing on management reporting relationships:

- “Managers and clinicians need to be on the same side; ‘we’, not ‘you’ should be heard much more. Managers and clinicians are together responsible, and neither should hold the other ‘to account’.”

The NOC Executive Team emphasised the importance of having a stable Executive Team for positive working relationships between managers and clinicians. For a long time, there was a culture in the NHS that expected managers to stay in the organisation for 2-3 years and then move on to a different organisation. Effectively, managers were influencing changes that they never saw through to the end. At the same time, many clinicians at the NOC were there for 30-40 years and they obviously did not appreciate the continuous churn of managers. Thus, having a stable and long-serving Executive Team at the point of merger had a positive impact on the working relationships between managers and clinicians.

Because the relationship with the University of Oxford is one of partnership rather than merger, concerns with respective team cultures did not arise in the same way as between the NOC and the ORH. Parties to academic-clinical collaborations built their relationship out of, but independent from, their institution's team values. Collaborations were seen to be between researchers or groups, not institutions. Further, many collaborations – especially those undertaken through the National Institute for Health Research (NIHR) Biomedical Research Unit (BRU) at the NOC – had been successful and productive long before the Joint Working Agreement:

- “I feel that those in the different organisations who need to communicate and/or collaborate have been doing so over the years anyway.”

The majority of respondents were positive about the impact of the merger on academic-clinical collaboration and teamwork. While university-employed clinical academics hoped that it would substantially improve the perception of clinical academics as “valued members of the team”, NHS-employed physicians hoped to feel more “pulled into the University”. Yet,

a minority of NHS physicians felt disenfranchised and isolated and were concerned that they would lose out to university clinical academics in terms of prestige and opportunities:

- “I have found the University to be rather isolationist, unwilling to include NHS staff in research projects etc., but always wanting the NHS to produce the data for projects and grant applications.”
- “I am very concerned that as a busy clinician with only a small research/teaching component I will be treated on a second tier compared to an academic appointment.”

Respondents repeatedly emphasised that both the NHS and the University urgently needed to pay more attention to staff support and development:

- “In both NHS and University there is a low level of attention to staff development, particularly of the non-clinical staff. Despite this there is a relatively high level of loyalty to the NOC, this loyalty and commitment is at risk if the non-caring attitude of management continues.”
- “The University could learn a thing or two about the value of people and not always doing things just to innovate and ‘be first’.”

### ***Hierarchical***

Those interviewed believed that the NOC had a lesser hierarchical culture compared with the ORH because of the NOC’s smaller size and greater team values. A major concern for post-merger integration was the danger of being “swallowed up” in a larger bureaucracy. Interviewees noted, however, that the ORH could have been perceived as much more bureaucratic simply because it was bigger and unfamiliar. At best, those interviewed hoped it was simply a matter of learning a new system, but this was tinged with a sense of loss; they had given up something that worked well for them:

- “NOC is a small ‘family’ – with relatively little bureaucracy and a friendly approach to performing day to day tasks, i.e. chat in the corridor, actions taken. This may be at risk if staff turnover/rotation high.”
- “There is concern that the familial environment of the NOC will be eroded by the merger. ORH is perceived to be a large inflexible juggernaut, concerned only with its own priorities.”

According to the NOC Executive Team, the size and scale of the NOC made it possible to develop a culture of informal contact and accessibility. Managers and clinicians were able simply to call in to the office of the Chief Executive and other members of the Executive Team, have a conversation in the corridor or at the coffee stand. Face-to-face contact made clinicians feel that they were able to get answers, that communication was easier, and that they were able to influence and be heard in a way that is much more difficult to achieve in a bigger organisation. The downside of this, however, is that written communications sometimes did not get through. Clinicians appreciated and expected more personal engagement.

Interviewees recognised that the best safeguards against the loss of the familial environment of the NOC were to be found in a devolved organisational structure. The NOC maintained its name as a hospital, and its clinical distinctiveness as one of seven devolved divisions within the new organisation. These were repeatedly emphasised by those interviewed:

- “Of things that were absolutely non-negotiable... one was the name.”
- “As a division, we are not the smallest of the divisions.”

The NOC Executive Team explained that in advance of the merger, the ORH was already devolving its management structure down to the level of divisions, and the NOC served as an exemplar of how other divisions should be run. Another important reason why devolving management down is imperative for the success of post-merger integration was the preservation of the NOC's identity and staff engagement. When the NOC's site was redeveloped long before the merger, there was a lot of concern among the staff that it would lose some of what made it the NOC. The Arts and Identity Programme helped bring together the old and the new (e.g. by finding place for old names and art in the new buildings and by creating a mural that depicted the whole history of the organisation), and everyone at the NOC was engaged in that process.

Interviewees maintained that the NOC and the University had distinct but related missions, and systems of governance that reflected these differences. They did not deem these differences as a hindrance and accepted the need to learn how to operate effectively within the two systems. Most believed that the NOC, and the NHS in general, were much more hierarchical than the University, yet some commented that the politics in the University could be as counterproductive as the hierarchy in the NHS:

- “The NHS is target driven from central Government. The talents and time of many able individuals is sometimes wasted in meeting these goals, particular where the benefit to patients is in doubt. Conversely, the University fosters innovation and allows individuals more freedom to excel in their areas of interest.”
- “The politics in the University appear even more divisive than they are in the NHS...this is very damaging for innovation as well as staff development.”

Insights from the NOC Executive Team reveal that because the NHS is a centrally run and funded health system there are indeed people in the NHS who feel that they have to perform certain tasks and duties because of central diktats or targets, which are not necessarily in the best interest of patients. Therefore, it would be desirable to move away from the hierarchical culture towards a more team-based and rational culture, where people would feel engaged and supported, and where entrepreneurial culture could flourish as well. However, the university-type entrepreneurial culture based on individual achievements and governance structures without clear reporting lines and accountabilities would not be optimal for health service delivery.

Integration of the NHS trust and University clinical trials and research governance teams is one aim of the strategic partnership. Those interviewed welcomed the idea with caution, still noting that change, however promising an opportunity to reduce bureaucracy, was still difficult and disruptive at the outset. For instance, research application processing times had initially increased:

- “I don’t necessarily know that things were done hugely differently. We all do the same key... GCP [Good Clinical Practice] training and we all deal with the same ethics committees, and so it’s more that it has just ground to a halt in terms of how long it takes to get anything through.”

In the same way that there are adjustments to be made to enable joint and more efficient research administration, there is recognition of the need to align NIHR research infrastructure:

- “There’s a younger generation who see the business necessity [of partnership and integration]. It was interesting to watch [the NOC’s] BRU and [the ORH’s] BRC renewal. This

time the bids were put forward with the BRC and BRU knowing what each other was doing. It's encouraging because it means that people are losing a little bit of an empire mindset and having a joint business plan instead. You just are not going to be competitive if it looks like you can't talk to your neighbour."

### ***Rational***

Respondents felt that it was easier to engage in the planning and implementation of the organisation's goals and objectives with managers at the NOC because ORH managers already had too many responsibilities. The view was that it is necessary to have a more efficient process for scaling up the NOC's best practices to the merged NHS trust:

- "...even though the ORH has the largest community falls programme there was no unified inpatient falls service. Instead of saying to us, great let's use what you have got to save time and get on with it, there was a painful ongoing deconstruction and now reconstruction of the process."

There was a general feeling among physician-scientists that the pursuit of greater savings, inadequate reimbursement for specialist services through the Payment by Results (PBR) system, and the increasing costs of repayments on Private Finance Initiative (PFI) capital projects, put additional strains on the post-merger integration with the ORH:

- "Staff at the NOC feel that we have been through many painful rounds of austerity measures in recent years in order to balance our books and are now joined with an organisation which has yet to start this process and is heavily in debt. The fear is that further such rounds will come and be applied equally to all divisions, which will disproportionately affect the NOC."
- "Risk of losing specialist services, unless fundamental funding flaws of PBR under-reimbursement, and PFI (over-costed due to paying interest on part of hidden national debts) are addressed."

The NOC Executive Team explained that whereas the ORH's finances fluctuated over the last five years, the NOC implemented a successful turn-around programme to make substantial efficiency savings and generate additional income. However, in the long run, the NOC would struggle to achieve Foundation Trust status and maintain its financial viability in line with the Government requirements because, unlike the ORH, the NOC did not have the breadth of the services that were sufficiently funded. The NOC had predominantly specialist services, which were not fully paid for under the PBR reimbursement system. Moreover, taking into account the diminishing cash envelope from the commissioners, the NOC had to deal with the stranded costs of the new buildings and infrastructure funded through PFI. In such circumstances, the NOC's Board of Directors felt that the best way to secure the NOC's long-term interests was to enter into a voluntary merger with an organisation that shared its priorities and thereby stay in control of the merger process rather than face the prospect of losing its specialist services and being deemed unviable in the future.

The majority of questionnaire respondents and interviewees were positive about the formal Joint Working Agreement and saw it as a potential basis for improving clinical services, research, and teaching:

- "I think that there will be an integrated strategy with the three strands [clinical, research, and teaching], as opposed to three completely different strategies."
- "Increased academic input helping clinicians to measure outcomes and improve practice, and increase profile of the NOC."
- "On both sides [clinical and research] there is also an increasing awareness about the patient centred-ness of it. Patients expect to have a strong say on what they want for the future."

A minority of respondents and interviewees had a negative or neutral outlook, however.

Some were concerned that one party to academic-clinical collaboration would benefit at the expense of the other. Some felt that “nothing will change and the NOC will carry on just as before”, or that adverse financial conditions would undermine the potential benefits of the merger and strategic partnership:

- “I think that the merger could constrain academic freedom, yet, if managed well, could free up the academic side to undertake higher-impact scientific endeavours.”
- “The merger has no definite clinical benefits for the NOC but there are benefits for the University. Clearer demarcation of funding streams to University or NHS work would be an advantage.”
- “Potentially could be greater true integration and cooperation between NOC and ORH and University for service, teaching, training and R&D innovation. Sadly initial responses, in face of massive savings to be made, resulting in cuts to SPA [standard programmed activity] time etc., indicate the reverse will be true, as doctors retreat into silos to defend their positions in the increasingly hostile environment.”

Those physician-scientists who participated in the study believed that in the current adverse financial situation, strong and fair leadership was required both locally and nationally, and expressed hopes that clinical leadership would be promoted. They commented positively on the changes in the ORH Executive Team that preceded and enabled the merger:

- “Under the old [ORH] exec team as was five years ago, I don’t believe we would have pursued a merger with them. That changed.”
- “Strong fair leadership will be critical at this difficult time of change locally and nationally for the NHS and academic medicine.”
- “Many clinicians are hoping that the management structures of the NHS are rebalanced towards enabling clinical leadership.”

The NOC Executive Team agreed with the salience of leadership to the merger. Whilst the long-term goal for the NOC and the ORH to come together was shared by many in the local health economy, including the Strategic Health Authority and commissioners, the NOC could not have contemplated a merger during the previous ORH administration. It was not in the NOC's interest given the management and direction of the ORH. When the new Chief Executive, Medical Director, and other members of the ORH Executive Team came in, they started to change the ORH and it developed to the point where it became in the interests of both organisations to come together. There was confidence around the leadership of the new ORH Executive Team that a merger would be of mutual benefit to both organisations and to the local health economy.

## **Discussion**

### **Main findings and implications**

As the number of mergers involving university hospitals and AHCs is set to grow, academic and clinical leaders are looking for new approaches to ensure success of post-merger integration and academic-clinical collaboration. In this article we used an organisational culture approach to examine the pre-merger and the preferred future culture at one of two NHS trusts during their post-merger integration and strategic partnership with the University of Oxford. Through this work and in comparison with earlier research [6], we identified key differences and similarities in the pre-merger culture across the two merging NHS trusts and the University, as well as a number of cultural issues that have important implications for the success of post-merger integration and for strategic partnership with the University.

First, qualitative responses indicated that respondents perceived the NOC to be more team-oriented and entrepreneurial, as well as less hierarchical. They were concerned about losing their identity and familial environment following the merger and also feared that in the merged organisation enterprise and innovation would be lost to complexity and bureaucracy. At the same time, parties in both trusts share common challenges such as paying more attention to staff development, working in partnership with managers, and overcoming the negative effects of current adverse financial conditions. It is important to note that our quantitative results do not support the qualitative finding that the ORH is more hierarchical than the NOC. We hypothesise that this is either because the small sample size did not allow reliable quantitative measurements or there are problems with the validity of the CVF instrument.

Second, pre-merger cultures of the clinical enterprise at both the NOC and the ORH are primarily distinct from the academic enterprise, suggesting that academic physicians and scientists work across two different cultures and that there is a formidable challenge in aligning these cultures to manage this cultural diversity. However, because the relationship between the merged NHS trust and the university is one of partnership rather than merger, there is an acceptance of needing to learn how to operate effectively in these two different cultures. Indeed, as many pointed out, they have long been doing so in their pre-Agreement collaborations. Major issues for respondents are how to reconcile different priorities in academic and clinical innovation and service delivery, how to build inclusive teams, and how to enable “symbiotic working” between the academic and clinical enterprises.

Third, the Joint Working Agreement served as an important ameliorating consideration in reaching merger and holds promise as a common relationship by which to address differences in organisational culture for successful post-merger integration. In so doing, it is important to ensure that despite their smaller size, the academic enterprise at the NOC is as influential as its clinical enterprise and that the NOC (as was) is as influential as the former ORH in its relationship with the university. Moreover, it is imperative to develop more efficient processes for sharing and extending best practice between the former trusts, while recognising that there are constraints on the extent to which some best practice can be shared and scaled up. The high levels of entrepreneurial culture observed in the University may not be unattainable in the NHS setting because some aspects of entrepreneurial culture are incompatible with the NHS service delivery model. Nevertheless, the influence of that culture may serve to encourage what entrepreneurialism is feasible and beneficial in a clinical context.

Fourth, the merger was viewed as a necessity, but also one with some promise. The majority of respondents detailed a movement from rejection to resistance, to a gradual willingness to enter into merger. There was a clear sense of the changing landscape in clinical research and service provision, and of the need to develop a common identity with the University. However, there is still a minority who feel demoralised and disenfranchised. They are particularly concerned with the dangers of receiving very little support from managers, the NOC losing its identity and clinical distinctiveness, and NHS physicians losing out to university clinical academics in terms of prestige and opportunities. These concerns need to be addressed urgently through effective staff engagement strategies.

Fifth, we found that changes aimed at strengthening translational research and NHS/university collaboration were disruptive at the outset, but that those who needed to collaborate had been doing so anyway. Respondents particularly stressed the importance and positive impact of the NIHR Biomedical Research Unit (BRU) for translational health research and innovation across the academic and clinical enterprises at the NOC. A similarly positive impact of the NIHR Biomedical Research Centre (BRC) was found at the ORH [26]. Moreover, the Joint Working Agreement itself evolved from the joint governance arrangements for the NIHR BRC and BRU. Mergers of university hospitals with existing NHS/university collaborations and proposals for new collaborations should be assessed as to whether they add value to the existing collaborations in the long run, and any such merger should try to minimise the disruption at the outset.

Sixth, history shapes perceptions of organisational culture and successful post-merger integration. The history of separateness and lack of collaboration between the NOC and the ORH has created memories and stereotypes that negatively affect the staff's attitudes towards integration and collaboration. At the same time, the history of the NOC's success while being a separate organisation has helped the staff develop a strong shared vision, identity, and loyalty to their organisation that positively affect staff engagement. Likewise, the history of successful academic-clinical collaboration with the University of Oxford helped undertake strategic partnership with the University, which served as an important ameliorating consideration in reaching the merger. Preserving identities of the merging organisations within a devolved organisational structure is likely to have a positive impact on staff engagement.

Finally, the national policy context played a major role in setting the agenda for the merger as well as in influencing the post-merger integration and strategic partnership with the University. The government set its requirements for all NHS trusts to achieve Foundation Trust status, but then repeatedly changed application deadlines and rules, creating added uncertainty and complexity. What is more, the current adverse financial conditions and the unintended consequences of government health care reforms threaten to send doctors and academics retreating back into their silos. Strong fair leadership will be required both nationally and locally for the success of mergers and post-merger integration in university hospitals and academic health centres.

### **Strengths and limitations**

The main strength of this study is that it uses a systematic assessment of organisational culture as a means of assisting successful post-merger integration and academic-clinical collaboration in an AHC. This study provides empirical evidence to help academic and clinical leaders in a given AHC identify differences and similarities in culture across the academic and clinical enterprises and resolve cultural issues early in post-merger integration and strategic partnership with a university. Another strength of this study is that the richness and diversity of the qualitative data provides a degree of validity that cannot be achieved by quantitative methods alone. Academic and clinical leaders in other AHCs contemplating merger will benefit from an increased evidence based that the cultures of their legacy organisations may differ and that the CVF instrument may have limitations in AHC settings as mentioned below.

This study has several limitations. It focusses on the small sample of academic-physician-scientists at one merging trust, rather than all staff groups at two merging trusts. As noted elsewhere, the CVF instrument was not specifically designed for academic medicine [26], and there are concerns about the validity of the CVF instrument in non-academic settings as well [34]. The disagreement between the qualitative and quantitative findings regarding hierarchical culture may indicate problems with the validity of the hierarchical subscale. Moreover, respondents did not provide many comments on the differences and similarities in rational culture, and instead concentrated on the general contextual factors related to rational culture. Finally, the CVF instrument did not capture well the historical issues that the former NOC Executive Team deemed to be important for the success of the post-merger integration. Therefore, caution should be exercised in generalising the results of this study and in using the CVF instrument in other AHC settings without prior validation.

## **Conclusions**

The results of this study indicate that the cultures of two legacy NHS trusts differed, and that the cultures of the clinical enterprise at both legacy NHS trusts were primarily distinct from the academic enterprise. There are challenges in preserving a more desirable culture at one of the legacy NHS trusts, enhancing cultures in both legacy NHS trusts during their post-merger integration, and in aligning academic and clinical cultures following strategic partnership with a university. The seeds of success may be found in current best practice and good will. Strong fair leadership would be required both nationally and locally for the success of mergers and post-merger integration in university hospitals and academic health centres. Our findings have important implications for the integration of health care providers and the promotion of NHS/University partnerships that deserve further research.

It might examine staff engagement strategies and cultural interventions to manage the cultural diversity and expectation. Further research might also evaluate how such strategies and interventions impact on the success of post-merger integration and academic-clinical collaboration.

### **Competing interests**

JF is the former Chief Executive of the Nuffield Orthopaedic Centre NHS Trust and currently Director of Nursing and Quality, Thames Valley Area Team, NHS England. AMB is Dean of the Medical School and Head of the Medical Sciences Division, University of Oxford, and honorary consultant neurologist, formerly the Oxford Radcliffe Hospitals NHS Trust and currently the Oxford University Hospitals NHS Trust. PVO and KM declare that they have no competing interests.

### **Authors' contributions**

AMB jointly conceived of the paper with PVO, participated in its design, and helped to draft the manuscript. PVO conducted the survey and led the writing of the paper. KM conducted interviews and co-wrote parts of the paper. JF organised and led a group discussion with the former NOC Executive Team and critically commented on drafts. All authors read and approved the final version of the manuscript.

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## References

1. Kastor JA: *Mergers of teaching hospitals in Boston, New York, and Northern California*. Ann Arbor: University of Michigan Press; 2003.
2. Sussman AJ, Otten JR, Goldszer RC, Hanson M, Trull DJ, Paulus K, Brown M, Dzau V, Brennan TA: **Integration of an academic medical center and a community hospital: the Brigham and Women's/Faulkner hospital experience**. *Academic Medicine* 2005, **80**(3):253-260.
3. Choi S, Brommels M: **Logics of pre-merger decision-making processes: the case of Karolinska University Hospital**. *Journal of Health Organization and Management* 2009, **23**(2):240-254.
4. Geisler BP, Widerberg KF, Berghofer A, Willich SN: **Leadership in health care: developing a post-merger strategy for Europe's largest university hospital**. *Journal of Health Organization and Management* 2010, **24**(3):258-276.
5. Kohn LT (Ed.): *Academic health centers: leading change in the 21st century*. Institute of Medicine Committee on the Roles of Academic Health Centers in the 21st Century. Washington, DC: National Academies Press; 2004.
6. Ovseiko PV, Davies SM, Buchan AM: **Organizational models of emerging academic health science centers in England**. *Acad Med* 2010, **85**(8):1282-1289.
7. Department of Health: *Equity and Excellence: Liberating the NHS*. London; 2010.

8. Department of Health: **Innovation Health and Wealth: accelerating adoption and diffusion in the NHS.** 2011  
  
[[http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_131299](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_131299)]
9. Harris II J, Ozgen H, Ozgen Y: **Do mergers enhance the performance of hospital efficiency?** *Journal of the Operational Research Society* 2000, **51**:801–811.
10. Fulop N, Protopsaltis G, Hutchings A, King A, Allen P, Normand C, Walters R: **Process and impact of mergers of NHS trusts: multicentre case study and management cost analysis.** *BMJ* 2002, **325**(7358):246.
11. Fulop N, Protopsaltis G, King A, Allen P, Hutchings A, Normand C: **Changing organisations: a study of the context and processes of mergers of health care providers in England.** *Social Science & Medicine* 2005, **60**(1):119-130.
12. Weil T: **Hospital mergers: a panacea?** *Journal of Health Services Research & Policy* 2010, **15**(4):251-253.
13. Macfarlane D, Butterill D: **From principles to practice: the management of post-merger integration.** *Healthcare Quarterly* 1999, **3**(1):35-39.
14. Goddard S, Palmer A: **An evaluation of the effects of a National Health Service Trust merger on the learning and development of staff.** *Human Resource Development International* 2010, **13**(5):557-573.
15. Shaw J: **Tracking the merger: the human experience.** *Health Services Management Research* 2002, **15**(4):211-222.
16. Dooley KJ, Zimmerman BJ: **Merger as marriage: communication issues in postmerger integration.** *Health Care Manage R* 2003, **28**(1):55-67.
17. Thier SO, Kelley WN, Pardes H, Knight AW, Wietecha M: **Success factors in merging teaching hospitals.** *Acad Med* 2014, **89**(2):219-223.
18. Cartwright S, Cooper CL: **The role of culture compatibility in successful organizational marriage.** *Academy of Management Executive* 1993, **7**(2):57-70.

19. Bligh MC: **Surviving post-merger 'culture clash': can cultural leadership lessen the casualties?** *Leadership-London* 2006, **2**(4):395-426.
20. Carleton JR, Lineberry CS: *Achieving post-merger success : a stakeholder's guide to cultural due diligence, assessment, and integration*. San Francisco: Pfeiffer; 2004.
21. KPMG: *Unlocking the shareholder value: the keys to success. Mergers & acquisitions, a global research report*. London: KPMG; 1999.
22. Pellegrini VD, Jr.: **Mergers involving academic health centers: a formidable challenge**. *Clin Orthop Relat R* 2001(391):288-296.
23. Fuller CW, Vassie LH: **Assessing the maturity and alignment of organisational cultures in partnership arrangements**. *Employee Relations* 2002, **24**(5):540-555.
24. Plewa C, Rao Hill SL: **Exploring organisational culture difference and relationship performance: Perspectives from service industries**. In *Australia & New Zealand Marketing Academy Conference*. Dunedin, NZ: ANZMAC; 2007.
25. Peck E, Dickinson H: *Managing and leading in inter-agency settings*. Bristol: Policy Press in association with Communitycare; 2008.
26. Ovseiko PV, Buchan AM: **Organizational culture in an academic health center: an exploratory study using a Competing Values Framework**. *Acad Med* 2012, **87**(6):709-718.
27. Mannion R, Brown S, Beck M, Lunt N: **Managing cultural diversity in healthcare partnerships: the case of LIFT**. *J Health Organ Manag* 2011, **25**(6):645-657.
28. Mallon WT: **The alchemists: a case study of a failed merger in academic medicine**. *Academic Medicine* 2003, **78**(11):1090-1104.
29. NOC: **Annual Accounts 2009/10**. Oxford: Nuffield Orthopaedic Centre NHS Trust (NOC); 2010.
30. ORH: **Annual Accounts 2009/10**. Oxford: Oxford Radcliffe Hospitals NHS Trust (ORH); 2010.
31. ORH: *A business case for the integration of the Nuffield Orthopaedic Centre and the Oxford Radcliffe Hospitals*. Oxford: Oxford Radcliffe Hospitals NHS Trust (ORH); 2011.

32. Burrough EJR: *Unity in diversity: the short life of the United Oxford Hospitals*. Abingdon: Burgess & Son; 1978.
33. Dewhurst K (Ed.): *Oxford Medicine. Essays on the evolution of the Oxford Clinical School to commemorate the bicentenary of the Radcliffe Infirmary, 1770-1970*. Oxford: Sandford Publications; 1970.
34. Helfrich CD, Li YF, Mohr DC, Meterko M, Sales AE: **Assessing an organizational culture instrument based on the Competing Values Framework: exploratory and confirmatory factor analyses**. *Implementation Science* 2007, **2**:13.
35. Scott T, Mannion R, Davies H, Marshall M: **The quantitative measurement of organizational culture in health care: a review of the available instruments**. *Health Services Research* 2003, **38**(3):923-945.
36. Mannion R, Davies H, Scott T, Jung T, Bower P, Whalley D, McNally R: **Measuring and assessing organisational culture in the NHS (OC1). Produced for the National Co-ordinating Centre for the National Institute for Health Research Service Delivery and Organisation Programme (NCCSDO)**. NCCSDO; 2008  
[\[http://www.netscc.ac.uk/hsdr/files/project/SDO\\_FR\\_08-1501-091\\_V01.pdf\]](http://www.netscc.ac.uk/hsdr/files/project/SDO_FR_08-1501-091_V01.pdf)

## Figures

**Figure 1 The Competing Values Framework.** Adapted from: Helfrich CD, Li YF, Mohr DC, Meterko M, Sales AE: Assessing an organizational culture instrument based on the Competing Values Framework: exploratory and confirmatory factor analyses. *Implementation Science* 2007, 2:13.

**Figure 2 Organisational culture profiles of the current (pre-merger) cultures at the two merging NHS Trusts, University clinical departments, and the preferred future NHS Trust/University culture, according to 2010 (ORH) and 2011 (NOC) organisational culture surveys.** The preferred future NHS Trust/University culture refers to the culture that should be developed across the clinical and academic enterprises in the next five years to more successfully pursue the shared mission of academic medicine.

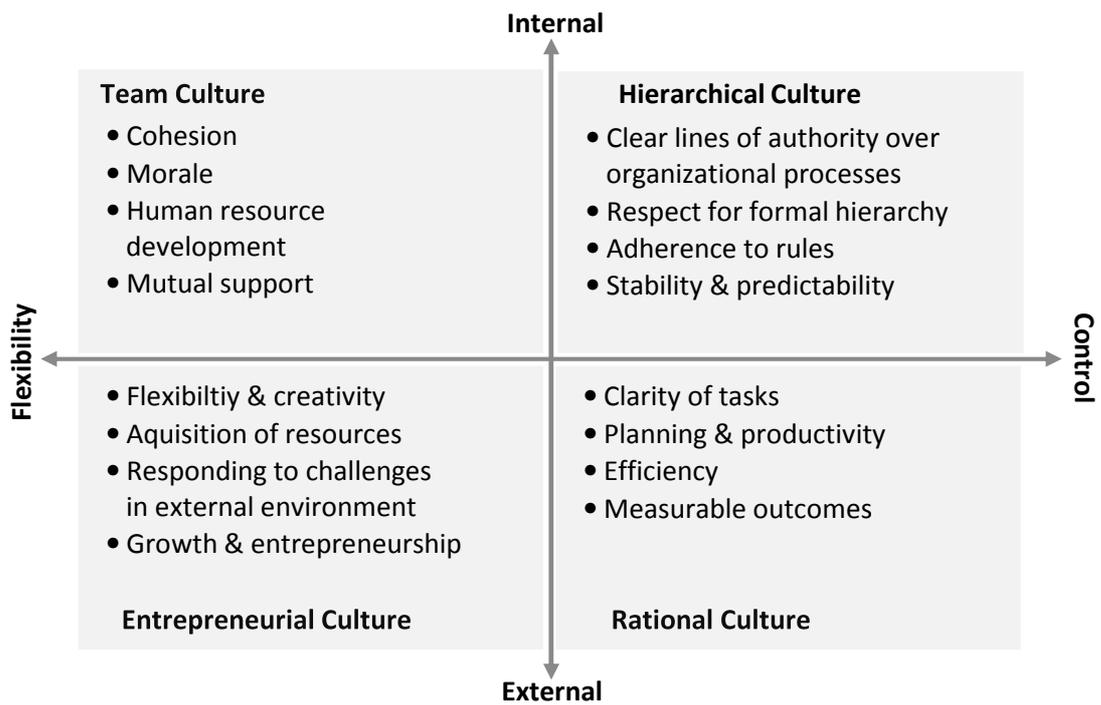


Figure 1

