

This report was commissioned and funded by Monitor, now part of NHS Improvement.

## **Benefits from mergers: lessons from recent NHS transactions**

### **1. Executive Summary**

1. A merger is one option for NHS providers seeking to address the ongoing challenge of providing the best possible services with the greatest efficiency. Understanding the benefits achieved in past NHS mergers can inform those Trusts<sup>1</sup> considering a merger about the benefits that their own transaction could deliver.
2. Monitor has commissioned this review of the benefits achieved in six past NHS mergers to assist Trusts in developing their understanding, and to help Monitor support Trusts considering a merger in future.
3. This report: (i) identifies the benefits to patients and commissioners that were realised by the six case study Trusts following their mergers; (ii) discusses the extent to which these mergers made the realisation of these benefits possible; and (iii) identifies factors common to those Trusts that experienced success in realising merger benefits.
4. The report does not seek to balance the costs and benefits that arose in the six merger case studies. It carries out a more limited consideration of the post-merger benefits that were achieved. Given this approach, the report may come across as more positive about NHS mergers than may be the case in other studies.<sup>2</sup> However, care should be taken in reading this report to remember that it does not seek to review each of these transactions as a whole.
5. In carrying out the six case studies, we have identified efficiencies and service delivery improvements that were realised after each merger; the extent of these benefits varies across the case studies. Savings in corporate overheads and clinical support services of around 1-3% of a merged Trust's turnover were generally realised relatively quickly post-merger.
6. Service delivery improvements were also made by each Trust post-merger, and were frequently accompanied by further cost savings. A variety of post-merger initiatives led to service improvements, including consolidating services onto fewer sites where larger numbers of patients are treated, improvements in treatment processes, and investment in estate and infrastructure.
7. Service improvements generally took longer to realise than savings from the rationalisation of corporate overheads and clinical support services (e.g. at least 2-3 years compared with 12 months). This was due to the greater complexity of these changes, and the need to ensure internal and/or external stakeholder support prior to implementation.
8. While interviewees were positive about their merger's contribution to the realisation of post-merger benefits, and in several cases there is a clear link between the benefits

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<sup>1</sup> The term 'Trust' is used in this report to refer to all NHS providers, and does not distinguish between NHS Trusts and Foundation Trusts.

<sup>2</sup> Monitor's review of the literature on NHS mergers that is being published at the same times as this report sets out its assessment of these studies.



anticipated from the merger and those subsequently realised, it has been difficult in relation to many post-merger service improvements to distinguish, with confidence, between: (a) those benefits that were enabled by the merger (and could not have otherwise been achieved); (b) those benefits that were facilitated by the merger (and were made easier to achieve as a result of the merger but might have been achieved without the merger); and (c) those benefits that arose from 'business as usual' initiatives that would have been implemented regardless of the merger.

9. One reason for this difficulty is the longer timeframe over which service improvements are achieved following a merger, and the number of other factors arising in the intervening period which also influence the realisation of these benefits, for example changes in commissioning structure, the 'tightening' and 'loosening' of NHS financial strategies or NHS clinical priorities over specific service waiting times or targets.
10. Several common themes emerge from the case studies in terms of those Trusts that experienced success in realising merger benefits. In particular: (i) the presence of detailed plans for post-merger operations; (ii) encouragement and support for clinical leadership and involvement in post-merger service planning and delivery; and (iii) clear, and ongoing, engagement with staff following the merger. The case studies frequently demonstrate a clear association between leadership skills, and clinical and staff engagement which results from that, and the realisation of post-merger benefits.
11. Where a case study merger could be characterised as a 'takeover' (i.e. where there is a clear understanding that the acquiring Trust will be applying its own operating model to the weaker Trust), it would appear that detailed plans for post-merger operations are particularly important to ensuring that benefits from the merger are achieved. However, where a case study merger could be characterised as a 'merger of equals' (i.e. between Trusts of equal size and influence), it would appear that clinical and staff engagement will be particularly important for identifying, and gaining support for (particularly from clinical staff), the adoption of common, improved, practices across the merged Trust that will underpin service delivery improvements.
12. In all cases, it would seem that the quicker a merged Trust can achieve a single organisational vision and culture, the greater the likelihood that merger benefits will be delivered.

## **2. Introduction**

13. A merger is one option for NHS Trusts to address the ongoing challenge of providing the best possible services with the greatest efficiency. Understanding the benefits achieved in past NHS mergers can inform Trusts considering a merger about the extent and the timing of benefits that might be realised from their own transaction. As a result, Monitor has commissioned a review of the benefits achieved in six NHS mergers to help NHS Trusts in developing this understanding and to inform its own guidance for NHS providers considering a merger.



14. Monitor plays a key role in working with NHS providers that are contemplating a merger to ensure that any proposal works well for patients.<sup>3</sup> While the Competition and Markets Authority (CMA) is responsible for reviewing the competition implications of mergers involving NHS Foundation Trusts, Monitor contributes to this process by advising the CMA on the likely benefits to patients and commissioners of these mergers.<sup>4</sup>
15. This report: (i) identifies the benefits to patients and commissioners that were realised by NHS Trusts following the six case study mergers; (ii) discusses the extent to which these mergers facilitated the realisation of these benefits; and (iii) identifies factors common to those Trusts that experienced success in realising merger benefits.
16. The report is not an evaluation of the overall costs and benefits of NHS mergers, or indeed, the overall success of merger for the six case study Trusts, and does not reach a view on the success or merits of the mergers. The focus of this report is on the post-merger improvements achieved by the Trusts in the six case studies.
17. In comparing the experiences of the six merged Trusts, we have sought to shed light on those factors that emerge as important enablers for the realisation of those benefits that were identified as having been achieved post-merger. In addition, by providing further evidence of the importance of these enablers (i.e. beyond what is already set out in the existing academic and management literature) this report seeks to provide useful insights that can be drawn upon by NHS organisations considering a merger, and which can also be drawn on by Monitor when evaluating the benefits likely to arise from a merger.
18. Aldwych Partners would like to thank each of the Trusts and interviewees for agreeing to participate. Without this generous assistance this review would not have been possible.
19. This report is set out as follows:
  - Section 3 provides an overview of the case study Trusts, including the events leading up to their mergers;
  - Section 4 sets out the benefits that the case study Trusts achieved following their mergers;
  - Section 5 discusses how the mergers contributed to the benefits achieved by the case study Trusts, and the extent to which the mergers were necessary for the realisation of these benefits;
  - Section 6 looks at the factors that the case study Trusts recalled were important to deliver various benefits or otherwise hindered or delayed achievement.

### **3. Overview of the case study mergers**

20. The six mergers between NHS providers that were selected for review as part of this study are set out in Table 1. These mergers took place between 2006 and 2012, and were

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<sup>3</sup> Monitor's engagement aims to improve Trusts' ability to plan, articulate and evidence how proposed mergers will benefit patients, and to help ensure that mergers between NHS providers proceed swiftly and at minimum cost where it is clear that they will deliver benefits for patients.

<sup>4</sup> For detailed information about Monitor's remit when advising the CMA and relevant definitions a number of guidance documents have been published by Monitor. In relation to merger benefits see: [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/340823/Monitor\\_mergerbenefits\\_guidance.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/340823/Monitor_mergerbenefits_guidance.pdf) and in respect of the types of mergers reviewed see [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/339830/CMA-MonitorShortMergerGuide-1.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/339830/CMA-MonitorShortMergerGuide-1.pdf)



chosen to cover different local health economies and different time periods since implementation.

**Table 1: Merger case studies**

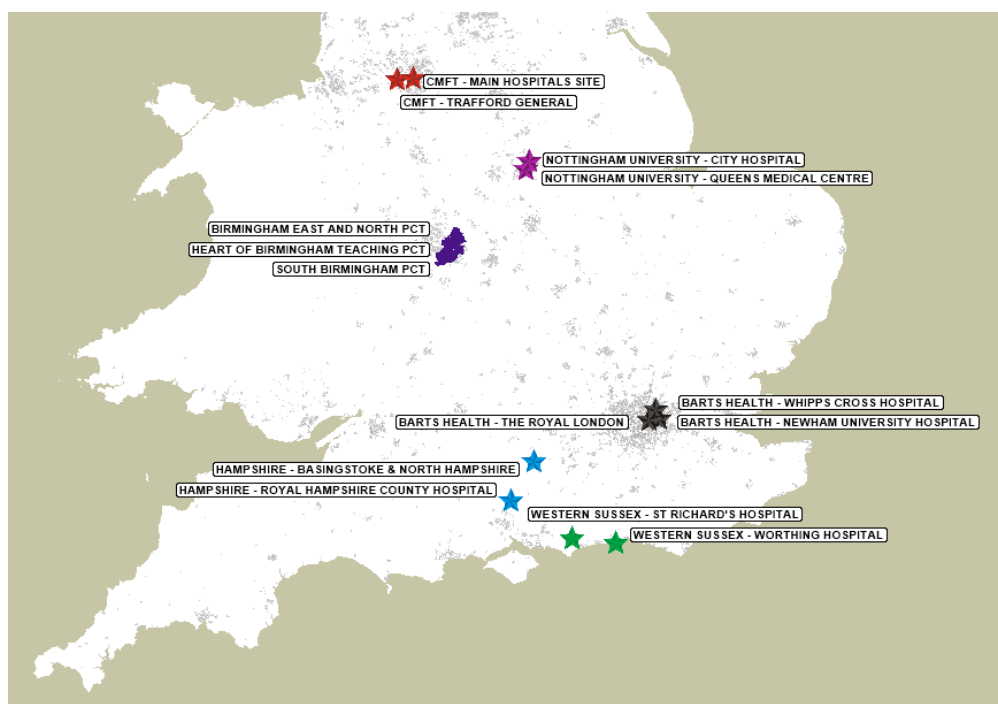
<b>Merged Trust</b>	<b>Merging Trusts</b>	<b>Date of Merger</b>
Nottingham University Hospitals NHS Trust	Nottingham City Hospital NHS Trust Queen's Medical Centre, Nottingham, University Hospital NHS Trust	1 April 2006
Western Sussex Hospitals NHS Foundation Trust	Royal West Sussex NHS Trust Worthing & Southlands NHS Trust	1 April 2009
Birmingham Community Healthcare NHS Trust	South Birmingham Community Health NHS Trust Birmingham East and North PCT community services provider arm Heart of Birmingham PCT community services provider arm	1 December 2010
Hampshire Hospitals NHS Foundation Trust	Basingstoke and North Hampshire NHS Foundation Trust Winchester and Eastleigh Healthcare NHS Trust	9 January 2012
Barts Health NHS Trust	Barts and The London NHS Trust Newham University Hospital NHS Trust Whipps Cross University Hospital NHS Trust	1 April 2012
Central Manchester University Hospitals NHS Foundation Trust	Central Manchester University Hospitals NHS Foundation Trust Trafford Healthcare NHS Trust	1 April 2012

21. Mergers between acute Trusts form five of the six case studies. The sixth case study involved a merger between three community health service providers.<sup>5</sup>
22. For each case study, interviews were held with four to five senior executives at the merged trust (e.g. chief executives, medical directors, nursing directors, chief operating officers) and, where possible, a commissioner that had insight into the transaction. Documents relevant to each merger were reviewed. This included, in most cases, the full business case for the merger, post-merger integration reports to the board of the merged trust, documents relating to post-merger changes in services, and other relevant internal papers and correspondence.
23. Based on this material, this overarching report draws on the views and evidence gathered from these case studies. A list of persons interviewed for this project is set out at Appendix A.

<sup>5</sup> It was not possible to include a mental health trust merger in this review. This was, in part, due to the much smaller number of mental health trust mergers in recent years. Those mental health trusts that were approached to participate in this study were unfortunately unable to do so.



### Map: Locations of the NHS providers in the case studies



24. The remainder of this section provides an overview of each the mergers that is the subject of a case study. In particular, it distinguishes between those mergers where the merging Trusts had similar size and status (referred to as 'mergers of equals'), and those mergers where one the merging Trusts imposed its management, procedures and process on the other merging organisation(s) (referred to as 'takeovers'). This distinction is helpful for understanding the approach of management (and the reaction of clinicians and staff) in each of the case studies, and how this has influenced the delivery of merger benefits (which is discussed in the subsequent sections of this report).
25. In each of the five merger case studies involving acute Trusts the transaction was motivated by concerns held by local health stakeholders about the ability of one, or all, of the Trusts involved in the merger to provide healthcare services without ongoing financial or other direct support from local commissioners.
26. The acquisition of Trafford Healthcare NHS Trust (Trafford) by Central Manchester University Hospitals NHS Foundation Trust (Central Manchester) in 2012 was the result of long running concerns by commissioners about Trafford being unable to balance its income and expenditure. Prior to the merger, Trafford was in receipt of an annual operating subsidy of between £10 million and £20 million each year.<sup>6</sup>
27. Trafford had sought, for an extended period, to forge an operating model that would allow it to remain independent, but subsequent to discussions with the Primary Care Trust (PCT) and Strategic Health Authority (SHA) it was eventually decided by the Trafford Board that this would not succeed. As a result, a formal process was carried out to identify a Trust

<sup>6</sup> Around the time of the merger, concerns also emerged about the quality of clinical services provided at Trafford. The implications of this for the success of Central Manchester's acquisition of Trafford are discussed later in this report.



willing to acquire Trafford with a view to restructuring such that services could be provided from its sites within financial balance and with safe patient outcomes. Central Manchester was selected as a result of this process.<sup>7</sup>

28. Winchester & Eastleigh Healthcare NHS Trust (Winchester), like Trafford, also had a persistent structural deficit of £5-6 million per annum. The local PCT and SHA, having concluded that Winchester would not make Foundation Trust status, selected Basingstoke & North Hampshire NHS Foundation Trust (Basingstoke) to acquire it. Basingstoke was at the time seeking to establish a larger catchment population to sustain its general and specialist acute service portfolio. As a result, Hampshire Hospitals NHS Foundation Trust (Hampshire) was formed in 2012.
29. The Central Manchester and Hampshire mergers are both examples of a strongly performing Trust acquiring a weaker Trust. South Birmingham Community Health NHS Trust's (South Birmingham's) merger with the community health provider arms operated by Birmingham East & North PCT and Heart of Birmingham PCT (establishing Birmingham Community Healthcare NHS Trust - Birmingham Community) also falls into this model of a stronger organisation acquiring weaker organisation(s).<sup>8</sup>
30. By contrast, the merger between Nottingham City Hospital NHS Trust (City Hospital) and Queen's Medical Centre Nottingham University Hospital NHS Trust (Queen's Medical Centre) in 2006 to create Nottingham University Hospitals NHS Trust (Nottingham) is better described as a merger of equals.
31. In this case, the transaction was triggered by a withdrawn application for Foundation Trust status by City Hospital. This led to the realisation by local commissioners that neither City Hospital nor Queen's Medical Centre was capable of achieving Foundation Trust status on its own given the persistent financial deficits at each Trust.<sup>9</sup> Following an SHA sponsored health care review, the Boards of both Trusts decided that a merger was the best option to achieve an ongoing balance between income and expenditure.
32. The merger between Royal West Sussex NHS Trust (Royal West Sussex) and Worthing & Southlands NHS Trust (Worthing & Southlands) to create Western Sussex Hospitals NHS Trust (Western Sussex) in 2009 was also a merger of equals, with both Trusts being of similar size and having a similar mix of services.<sup>10</sup> The Boards of the two Trusts decided to merge following a proposal to reconfigure services, led by the local PCT and SHA, which would have resulted in services being downgraded at one of the two Trusts. This service reconfiguration proposal was motivated by concerns held by the commissioners about the medium-term financial and clinical viability of services at both sites, and the need to

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<sup>7</sup> Trafford consisted of three sites, the main Trafford Hospital site and two smaller community hospitals at Altrincham and Stretford.

<sup>8</sup> The merger of the community health provider arms, however, was not instigated as a result of specific concerns regarding the viability of the two community health provider arms. Rather, under the Transforming Community Services programme that was adopted in 2009, all PCTs were obliged to separate their commissioning and provider functions. It was therefore the national policy directive that led primarily to South Birmingham's acquisition of these two providers and the establishment of Birmingham Community Healthcare NHS Trust (Birmingham Community). Further information about the Transforming Community Services programme can be obtained from the publication Department of Health, *Transforming Community Services: Enabling new patterns of provision*, January 2009.

<sup>9</sup> These deficits were estimated at the time of the merger to be around £6 million to £6.5 million annually at each Trust.

<sup>10</sup> Western Sussex achieved Foundation Trust status in 2012.





concentrate clinical expertise at a single site to ensure the provision of high quality care in the face of workforce pressures.<sup>11</sup>

33. The final case study is of the merger in 2012 between Barts and The London NHS Trust (Barts and The London), Whipps Cross University Hospital NHS Trust (Whipps Cross) and Newham University Hospital NHS Trust (Newham) to create Barts Health NHS Trust (Barts Health). This merger was also motivated by local commissioners' concerns about how each of these Trusts (to a greater or lesser degree) could best provide a full range of secondary and specialist health care services to the local population and achieve financial balance.
34. Barts and The London was the largest of the three merging Trusts, and many of its management staff secured roles managing the new Barts Health following an open competitive process for these management roles.<sup>12</sup> In this respect, the transaction looked like, and was – according to the executives we interviewed - perceived by some staff to be, an acquisition by Barts and The London of the other two Trusts. However, in other respects, it was more like a merger of equals in that Barts and The London was not in a strong financial position and had a number of ongoing programmes to change and improve how it provided services, with similar challenges being experienced at Whipps Cross and Newham.
35. Whether a merger is a 'takeover' or 'merger of equals' is an important influence on how the merged Trust goes about integrating the two merging organisations into a new, larger service provider, and how it tries to realise benefits from the merger. These issues are discussed in further detail in Section 6.

#### **4. Post-merger benefits achieved by case study Trusts**

36. This section describes the post-merger benefits achieved by the case study Trusts. These benefits fall into two areas: (i) greater efficiency in service delivery; and (ii) other improvements in service delivery (such as improvements in patient experience or clinical quality).<sup>13</sup>
37. Merger benefits can also be classified into improvements that have a direct impact on patients in a particular service area (e.g. through reducing average length of stay), and those that have a more indirect impact (e.g. cost savings that allow the delivery of additional or more specialist services).
38. Sections 5 and 6 explore the extent to which mergers have been necessary to bring about these benefits, and the common factors that emerge from the case studies in relation to those Trusts that have been successful in realising certain benefits. The remainder of this

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<sup>11</sup> See, for example, Royal West Sussex NHS Trust and Worthing & Southlands Hospitals NHS Trust, *Full Business Case for Merger*, version for review by South East Coast SHA, 18 February 2009.

<sup>12</sup> Annual revenue at the three hospitals at the time of the merger was: Barts and The London (£820 million), Whipps Cross (£230 million) and Newham (£150 million).

<sup>13</sup> In some cases, a post-merger change (e.g. to the delivery of clinical services) may deliver both cost savings and improvements in services, and thus fall into both of these categories.



section discusses the post-merger benefits achieved by the case study Trusts in terms of improved efficiency and other service improvements.

#### 4.1 More efficient service delivery

39. This section reviews the post-merger cost saving measures taken by the case study Trusts, and which, as a result, contributed to more efficient service delivery by these Trusts. The case studies show that these cost saving measures were in five broad areas, namely:
- *Corporate overhead savings*: through adopting a unified management structure with a single Board, Chief Executive and senior management and consolidating corporate support functions, such as finance, HR, IT, procurement, and estates management, and the process and/or purchasing functions within these teams;
  - *Clinical support savings*: through consolidating the management of clinical services, and other support roles, such as infection control, governance, pathology and pharmacy;
  - *Other workforce savings*: through harmonising job roles and salary bands across the merged Trust, harmonising terms and conditions across the merged Trust, reducing expenditure on temporary staff, and in one case, a total workforce reduction programme;
  - *Clinical service delivery savings*: through changing the way in which services are delivered (e.g. through consolidating the delivery of services onto fewer sites or process improvement) which has reduced the cost of service delivery (e.g. by reducing length of stay); and
  - *Estate rationalisation*: through using the available estate more efficiently, which has allowed, for example, sites or parts of sites to be disposed of.
40. Consistent with the aims of this project, the focus in this section is on the individual post-merger cost-saving measures that were implemented by the case study Trusts rather than assessing each Trust's overall financial performance post-merger. Nevertheless, the section concludes by reviewing each Trust's total estimated cost savings post-merger, as discussed during our interviews with the executives, and the extent to which the financial viability concerns that motivated several of these mergers (as set out in Section 3 above) were addressed.

##### *Corporate overhead and clinical support savings*

41. All of the case study Trusts realised savings from consolidating corporate and clinical support functions. Savings from adopting a unified management structure, consolidating corporate support functions and consolidating the management of clinical services, were generally achieved within the first 6-12 months of the merger.
42. Examples of changes to clinical support functions and purchasing leading to financial savings included laboratory services being centralised to a single location for non-time critical "cold" tests (with smaller "hot" labs remaining on-site) for both Barts Health and





Western Sussex. Nottingham and Hampshire also explained how clinical purchasing changes were implemented to standardise orthopaedic surgery inputs and realise savings.<sup>14</sup>

43. The speed with which corporate overhead and clinical support savings were realised depended on the extent to which the merging Trusts had a detailed organisational structure planned for the merged organisation. Hampshire and Birmingham Community, for example, both had detailed plans ready and were able to announce their planned new structures on the day the merger was completed. This allowed new organisational structures to be implemented shortly after the merger, and for the related savings to be realised within the shortest possible timeframe.<sup>15</sup>
44. Even at those case study Trusts where decisions on the structure of the merged organisation were only made once the merger had been completed, most savings from management and back office consolidation were still achieved within the first 12 months of the merger.
45. Most of the case study Trusts adopted a unified leadership and management structure for their clinical services on a Trust-wide basis. However, several case study Trusts also maintained site-based management structures alongside service-level management structures.
46. Nottingham, Western Sussex, Hampshire, and Barts Health all adopted a single service director (i.e. one manager for each service) across all sites with little or no additional site based operations management. Birmingham Community also adopted a pan-Birmingham management structure, without maintaining any of the geographic delineations that had existed prior to the merger with the three separate, geographically-based community providers.
47. Central Manchester maintained Trafford as a distinct clinical division, so the primary managerial role has been a site-based overall Divisional Director role for the Trafford Hospital division (i.e. a manager with responsibility for the hospital site). However, for some services Central Manchester also implemented single managerial service working across sites. The executives from the Trust told us that this clinical management structure has required ongoing adjustment as the demands of the roles became apparent over time. This was also reported by executives from Hampshire and Barts Health where site-based operations management were implemented following a later review of management structures. (Site-based managers make day-to-day decisions about various critical site-based issues, such as bed management and staff rosters.)
48. Service-level management structures may be lower cost than site-based management or matrix structures where they allow two or more managers to be replaced with a single position. Where a merged Trust has implemented service-level management, and

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<sup>14</sup> We were told during the case studies that changes made to standardise purchasing of clinical inputs (e.g. hips and knees) are not generally significant in the scheme of entire Trust financial turnover. However, where these changes are made they can lead to important savings, see the example of Northumbria Healthcare NHS Foundation Trust where standardising these clinical inputs led to funding being available for three additional orthopaedic consultants <https://twitter.com/FelicityTHF/status/661182776188760065>.

<sup>15</sup> Requirements for staff consultation mean that there will always be some delay in the implementation of a new organisational structure for any newly merged Trust.



subsequently adds additional site-based management, at least some of the cost savings arising from the implementation of service-level management may be lost. However, the direct costs of these different structures is probably less important than their broader effect on the Trusts' ability to integrate clinical services and deliver merger benefits. The link between the management structure for clinical services and the realisation of merger benefits is explored further in Section 6.

#### *Other workforce cost savings*

49. This section discusses other workforce expenditure savings that the case study Trusts were able to realise through changes to workforce remuneration, and replacing temporary (agency and locum) staff with permanent employees. These savings on workforce costs were in addition to those that came about through integrating corporate and clinical support functions, and changing the way in which clinical services are delivered (both of which are discussed elsewhere in this section).
50. Central Manchester realised savings from bringing job roles and salary bands at Trafford in line with those elsewhere at Central Manchester. We were told that Trafford had, prior to the merger, been categorising jobs at higher pay grades as a means of attracting and retaining staff. Harmonising job roles and salary bands at Trafford with those elsewhere at Central Manchester was a source of cost savings.<sup>16</sup> Hampshire also told us that it had realised some savings by standardising consultants' terms and conditions (e.g. in relation to extra duty payments to consultants for additional work or for working at certain times of day or weekend).
51. Harmonisation of job roles and salary grades can, however, present significant challenges not only in terms of realising these potential savings but also in terms of having a broader impact on workforce morale and staff retention. This issue is explored further in Section 6.
52. Hampshire told us that it was also able to realise savings by having out-of-hours work shared across staff at the merged Trust rather than running a separate out-of-hours rota for each Trust, and by reducing some of the locums required to maintain rotas because of the larger clinical teams resulting from the merger.
53. Several Trusts told us that following their merger they had been more easily able to recruit permanent staff, and reduce their reliance on temporary staff, thus achieving cost savings. Barts Health, for example, was able to permanently fill six A&E consultant vacancies previously maintained by locums at Whipps Cross following the merger. (We were told that, prior to the merger, there were only two permanent A&E consultants at Whipps Cross.) Trust executives told us that consultants were attracted to the merged Barts Health due to the opportunities that it was able to offer in terms of working across the merged Trust, including at the major trauma centre that it operates. Improved ability to recruit was also experienced by Birmingham Community which filled a large number of Health Visitor vacancies following merger, and Hampshire was able to attract sub-speciality consultants for its Cardiology service.

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<sup>16</sup> This harmonisation process delivered cost savings by re-grading roles at Trafford Hospital on a like-for-like basis with other roles across the merged Trust. While existing staff have their terms and conditions protected from any changes as a result of a re-grading of their position, new staff are recruited at new, lower cost, staff grades.



54. In other cases, following the merger, case study Trusts were able to recruit to vacancies which the pre-merger Trusts had been unable to fill. This change from temporary workforce to permanent staff is usually expected to contribute to improved clinical services. This effect is discussed further in the following section on post-merger service improvements.

#### *Clinical service delivery savings*

55. Changes in the delivery of clinical services at the case study Trusts, such as through service consolidation or process improvement, also delivered cost savings (as well as improvements in patient outcomes, which are discussed in the next section).
56. Efficiencies and cost savings arose through being able to deliver a shorter length of stay for patients and rationalising the estate used to deliver services. The various initiatives to relocate services and improve clinical processes that delivered these savings are discussed in further detail below.
57. The timescale for achieving changes to clinical service delivery, and realising the associated savings, at the case study Trusts was usually two to three years, and in some cases longer. Again, the reasons for this are discussed in more detail in the following section.

#### *Estate rationalisation*

58. Both Central Manchester and Birmingham Community were able to rationalise estate holdings following their mergers. Central Manchester included quite specific estate plans in its bid to acquire Trafford in order to fund investment into infrastructure at Trafford Hospital. As it turned out, the SHA led the disposal of one of the small hospitals and redevelopment programme at Trafford prior to the merger proceeding. Further estate rationalisation is subject to the relocation of services, and proposals to relocate services were under consideration at the time we spoke with Central Manchester executives.
59. Birmingham Community undertook a significant estate rationalisation programme following its merger that led to two areas of improvement. First, financial savings arising from reducing its portfolio of 420 sites at the time of merger in 2010 to 330 sites in September 2015, with an expectation of a further reduction to 290 sites by March 2016.<sup>17</sup> Second, a less quantifiable benefit from the estate rationalisation programme has been the co-location of all corporate support staff in a single office compared with eleven separate locations previously. We were told by the Trust executives that this has significantly improved communications, and helped the process of embedding a new organisational culture across the Trust.

#### *Estimates of post-merger cost savings*

60. Estimates of post-merger cost savings at the case study Trusts are generally limited to the savings that were achieved in the first one to two years following the merger. This reflects the usual timescale within which each case study Trust had programmes in place for

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<sup>17</sup> Unfortunately, the Trust did not have any analysis available to show the expected financial savings from this particular change following merger, which was bundled into broader financial savings initiatives across the Trust.



specifically managing and monitoring merger-related integration initiatives prior to returning to “business as usual”.

61. The case study Trusts’ estimates of the savings arising from their mergers will therefore capture the savings that occurred within this period, such as integrating corporate and clinical support functions as well as savings arising from general workforce measures (such as harmonisation of job roles and pay grades). However, savings arising from changes in clinical service delivery tend to be outside the scope of these estimates due to the longer implementation timeframe.
62. Keeping these timing issues in mind, estimates of annual recurring merger-related cost savings ranged from one and three per cent of turnover at Birmingham Community (£2.2 million)<sup>18</sup> and Hampshire (£8 million) respectively; five per cent was realised from Central Manchester (£40 million), where major cost savings from changes in clinical service delivery were delivered earlier than usual given the ‘takeover’ style of merger; and ten per cent (£53 million) at Nottingham, where a major cost reduction exercise was carried out post-merger through a significant reduction in workforce posts across all clinical and non-clinical teams at the Trust.
63. Differences between these case studies mean that it is very difficult to be definitive about the scale of cost savings that might be expected from mergers more generally. For example, the changes following merger that were implemented at Trafford reduced its expenditure base from £90m annually to £50 million (a 45 per cent reduction in expenditure albeit a smaller impact on the turnover of the merged organisation, as noted in the above paragraph). This also informs the potential scale of change that can be implemented in a merger where a strong organisation is taking over a smaller organisation and has commissioner support to make service changes following consultation.
64. From the interviews with executives from the six case studies it seems reasonable to expect that most NHS mergers are capable of delivering a significant level of recurring savings from consolidating back office and clinical support functions, and a reasonable estimate of these savings, based on these case studies, is in the region of 1-3 per cent, with further savings possible for changes in clinical service delivery.<sup>19</sup>

#### *Post-merger cost savings and financial balance*

65. Financial savings, as set out in Section 3, were a motivating factor for several of the case study mergers. Trafford, both Nottingham Trusts, Winchester, and Whipps Cross all had ongoing structural financial deficits that the Trusts, commissioners and local SHAs had not been able to reduce in the years leading up to the merger. Each Trust was in receipt of ongoing external subsidies from commissioners to cover these deficits where recurring annual expenditure was greater than annual income.

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<sup>18</sup> The lower savings figures at Birmingham Community Healthcare most likely reflect the fact that South Birmingham Healthcare did not acquire two freestanding organisations with all of the supporting overheads, but the community health operating divisions of two PCTs. This means that there would have been less opportunity to make savings through reductions in corporate overheads.

<sup>19</sup> The post-merger savings of ten per cent of turnover made by Nottingham in the year following its merger should be regarded as an outlier in that the significant staff reductions made by the Trust following its merger is something that the Trust executives told us would now be unlikely given how more recent NHS guidance on staffing ratios is applied by managers and regulators.



66. In three out of these four mergers (Central Manchester, Nottingham and Hampshire), cost saving initiatives that were implemented post-merger meant that ongoing subsidies that had been provided by commissioners to poorly performing pre-merger Trusts could end. Several of these Trusts are once again incurring deficits. However, this appears to be related to the broader financial constraints that the NHS is operating under rather than a recurrence of the Trust-specific financial problems that these Trusts were experiencing prior to their mergers. The fourth merger, at Barts Health, has not, however, been similarly successful in achieving the cost savings necessary for annual income to exceed annual expenditure.<sup>20</sup>
67. In Western Sussex, the short-term financial viability of both Trusts was not under question. Both Trusts had returned to surplus prior to the merger, albeit following a previous period in which both had recorded significant financial deficits. Following the merger, however, cost savings at Western Sussex were sufficient to allow it to repay historic debt, and to meet the financial surplus requirements necessary to achieve Foundation Trust status.
68. In summary, the case studies show that there are several examples of past Trust mergers (three out of four) where the cost savings necessary to achieve annual financial balance have been achieved following the merger, even in circumstances where one or both of the pre-merger Trusts has experienced persistent annual financial deficits prior to merger.<sup>21</sup> Of course, the scale of the financial challenges now faced by NHS providers are such that it is not possible to conclude that future mergers would necessarily achieve the same annual financial balance as some of these past mergers. Nevertheless, it can be seen from these examples that mergers can be helpful in delivering recurring cost savings for NHS providers.

## 4.2 Service Improvements

69. This section reviews the post-merger actions taken by the case study Trusts which contributed to the delivery of service improvements by these Trusts following their mergers. The case studies show service improvement measures in five broad areas, namely:
- *service consolidation*: where activity and/or expertise in a speciality was concentrated in fewer locations across the merged Trust to improve services and in some instances support the introduction of additional sub-speciality consultants;
  - *process improvement*: where changes in the process by which care is delivered to patients were put in place so as to improve patient outcomes;
  - *estates and infrastructure investment*: which enabled improved patient experience as well as clinical aspects of care (e.g. reduced infection risk);

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<sup>20</sup> It is worth noting that the Barts Health merger was one of the most recent in the case study cohort, being completed on 1 April 2012, and has thus had less favourable financial conditions in which to operate compared with earlier NHS mergers.

<sup>21</sup> Details of the pre-merger financial performance of the merging trusts are set out in Section 3.



- *improved recruitment*: which aided the delivery of care through enabling recruitment to persistent vacancies and/or allowing the Trust to attract high calibre clinicians and managers; and
- *increased research and development*: where the merged Trust has been able to increase its research and development activities for the benefit of its patients.

70. As with the discussion of cost saving measures in the previous section, the focus in this section is on the various individual post-merger measures taken by the case study Trusts to improve services, rather than assessing each Trusts' overall performance post-merger. Nevertheless, the section concludes with a general discussion of how persistently poor patient outcomes that had motivated several of these mergers (as set out in Section 3) were addressed following merger.

#### *Service consolidation*

71. All of the case study Trusts have changed how services are delivered across the new combination of hospital sites, to some degree, following the mergers. The extent of these service changes varies significantly between the case studies, and in some cases the changes were a planned outcome of the merger, while in other cases, it was a response to information that emerged following the merger.
72. The acute Trusts that most extensively changed the location of service delivery post-merger were Nottingham, Western Sussex and Central Manchester.
- At Nottingham, emergency and urgent care and trauma services were largely concentrated at Queen's Medical Centre, and planned services, such as elective orthopaedics, were concentrated at City Hospital.
  - At Western Sussex, inpatient services were moved to Worthing Hospital from Southlands Hospital which now only provides outpatient and day-case services. At the same time, hip and knee surgery was moved from Worthing Hospital to St Richard's Hospital to accommodate additional inpatients at Worthing given the transfer of services from Southlands. In addition, Ophthalmology Surgery is now offered at St Richard's Hospital and Southlands Hospital, whereas prior to the merger it was only available at Worthing Hospital.
  - At Central Manchester, 24/7 A&E and inpatient surgical services were moved from Trafford Hospital, and this site now primarily offers urgent care services, medical inpatient care, elective orthopaedic inpatient care, day case surgery, and outpatient services.
73. Less extensive changes to service locations were implemented by Hampshire, Barts Health and Birmingham Community.
- Hampshire and Barts Health have both reorganised some services across the merged hospital sites, but this has been limited to one or two services (e.g. stroke and cardiology at Hampshire, and elective orthopaedics at Barts Health).





- For community services providers, like Birmingham Community, changes to where a service is delivered from is a slightly different issue compared with acute Trusts given that patient care is frequently delivered in the home and other community settings, rather than from fixed locations, such as hospitals. Nonetheless, Birmingham Community has also substantially changed how patients can access the services it delivers. In particular, the emphasis on delivering a uniform set of services across the city of Birmingham has resulted in services that were only available in one area prior to the merger (e.g. Rapid Response Teams and IV at home services in South Birmingham) now being available across Birmingham. Greater access to these services, which we were told has reduced admissions to acute care for some patients, have been delivered following the merger.
74. Central Manchester's planning for the Trafford acquisition was predicated on significant changes to the range of health care services provided from Trafford post-merger. These changes were not included explicitly in the bidding process, but were agreed with commissioners and the clinical community as part of the post-merger discussions. Local commissioners subsequently consulted on these changes post-merger.<sup>22</sup> Changes to service locations and a reduction in service duplication across the two sites was also anticipated prior to the Nottingham merger (although the time period for delivery of these changes was settled in the years following merger). In Western Sussex, proposals to change the location of service delivery came about after the merger as an outcome of the clinical strategy developed by the newly merged Trust (as well as in response to newly emerging clinical performance information – see below).
75. In each case, formal public consultation and decision-making on proposals to change the services took place following the merger, rather than being a part of the merger review process. The procedural process associated with changing services significantly (i.e. securing support through a public consultation process and avoiding legal challenge) mean that many Trusts contemplating a merger are very circumspect in discussing how the services might change before the consultation process, and so before a merger is completed.
76. The time between merger and public consultation can, however, vary significantly. At Central Manchester, where the viability of the merger was dependent on services being removed from Trafford, a public consultation took place six months after the merger. (The provider told us it was ready for the consultation to have been initiated by commissioners even earlier.) In Western Sussex, where proposals to change services were only developed as part of the clinical engagement process post-merger, public consultation on these proposals took place two years after the merger, in early 2011. At Hampshire, where centralisation of stroke and cardiology services did not require public consultation (i.e. there was, in effect, no removal of service for the local population requiring consultation), implementation occurred immediately after the merger.
77. Post-merger service changes have, in some cases, been a planned strategy for service improvement and merger integration, but in other cases, it has been a response to poor patient outcomes that have only come to light after a merger. At Western Sussex,

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<sup>22</sup> The consultation was called *A new health deal for Trafford*, A consultation on plans to redesign hospital services in Trafford and available at [http://www.manchester.gov.uk/download/meetings/id/14050/6iv\\_full\\_consultation\\_document](http://www.manchester.gov.uk/download/meetings/id/14050/6iv_full_consultation_document).



emerging information about poor patient care at Southlands Hospital following the merger (that is high standardised mortality rates for patients and a failed CQC theatre inspection) gave added impetus for the clinical strategy that was being developed by the newly merged Trust, and in particular, focused the clinical strategy on where services could be safely located.

78. Elective orthopaedics was the service most commonly relocated in the merger case studies. Nottingham, Western Sussex, Barts Health and Central Manchester all chose to centralise this service on one site with a view to managing patient waiting times more effectively, reducing the number of cancelled operations, and reducing length of stay. Western Sussex, for example, told us that length of stay halved for hip and knee surgery patients following the concentration of these services at St Richard's Hospital as it allowed a comprehensive rehabilitation service to be developed around the larger orthopaedic service. The other Trusts achieved service improvements and benefited from dedicating theatres on one site to elective services, keeping emergency care patients separate on an emergency-focused hospital site.
79. While this was not addressed directly with executives at the case study Trusts, it is possible that the large patient volumes in this specialty explains some of the priority given by Trust executives to centralise this particular set of services. That is, many Trusts are likely to see improvements in patient outcomes (see the above paragraph for examples) for significant numbers of patients from centralising this service following a merger.
80. Other services that were frequently relocated at the case study Trusts included interventional cardiology, which was consolidated at both Hampshire and Western Sussex. Nottingham told us that constraints arising from the building estate was the only reason why interventional cardiology had not been centralised at Queen's Medical Centre following merger. Other services subject to relocation and centralisation to a single hospital site in the Trust case studies included complex breast surgery, nephrology, renal services and ophthalmology at Western Sussex, and colorectal and upper gastrointestinal surgery at Nottingham.
81. Benefits from consolidating services at a single hospital site following the case study mergers included higher quality care (where patients were moved from hospitals that were experiencing a higher HSMR, such as Trafford and Southlands Hospitals, to hospitals that delivered better outcomes under this measure), reduced length of stay (e.g. hip and knee surgery at Western Sussex see paragraph 81), and fewer cancelled operations with positive consequences for patient waiting times (e.g. orthopaedic surgery at Nottingham and Barts Health).
82. Reviews of how services could be optimally delivered by the newly merged Trusts also resulted in an increased number of locations from which services were delivered in several cases. This included, for example, the roll out of the Rapid Response Teams and IV at home services across Birmingham, and in Western Sussex, Ophthalmology Surgery changed from being provided at one location to two.
83. In this context, we considered the proposition put forward by some Trust executives that the merger preserved the ability of patients to access some health care services from sites that might have been 'lost' if the merger had not proceeded. The most specific example of



this in the case studies related to the commissioner-led reconfiguration of services in Western Sussex, which proposed that only a single hospital site in the area provide A&E, Consultant-led Maternity, and Paediatric services. Following the Western Sussex merger these services continue to be provided by both Worthing and St Richards Hospitals, and thus closer access to these services has been maintained for patients.<sup>23</sup>

84. It is difficult to reach a conclusion on whether, in fact, these services would have been reconfigured in the way commissioners had proposed in Western Sussex (in the event of the proposed reconfiguration process continuing and the merger not happening) because additional consultation and approval requirements may have prevented commissioners from achieving their proposed view.<sup>24</sup>

#### *Process improvement*

85. This section describes the process improvements undertaken by the case study Trusts to change the way in which services are provided by existing clinicians in existing locations so as to achieve better patient outcomes. Process improvement strategies were often referred to by executives at the case study Trusts as 'rolling out best practice' or 'process standardisation'.
86. Process improvement, as a means of delivering higher quality services, was a key part of the post-merger strategy at Western Sussex, Birmingham Community and Central Manchester. Barts Health and Hampshire, have also pursued process improvement, albeit on a more limited basis.
87. At Central Manchester, for example, the Trust had a clear, documented operating model for consultants that it rolled out to services at the newly acquired Trafford Hospital. It was explained to us that the terms of the merger were very clear, it was an acquisition of Trafford by Central Manchester, and with that came the adoption of Central Manchester's approach to service delivery.
88. More collaborative approaches to identifying and adopting process improvements were employed at other case study Trusts. For example, at Western Sussex, where any of its sites had a demonstrably superior set of practices (or patient care pathway), then this was adopted across the merged Trust. In other cases, process improvements were based on evidence and experience from outside the Trust, rather than through reference to existing practice within the Trust. A similar approach was described by Birmingham Community.
89. Unlike the service consolidation changes discussed in the section above, with the common emphasis on elective orthopaedics, there was no particular specialty or care pathway where process improvement efforts were focused for the case study Trusts. Examples of where process improvements were implemented include stroke, trauma, renal and neurosurgery services at Barts Health, elderly care at Hampshire, and antibiotic prescribing, elderly care admissions and infection control isolation policies at Western Sussex. This variation is likely to reflect the different opportunities available to each Trust

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<sup>23</sup> That said, the benefit of more local access being maintained needs to be weighed against the benefits of the proposed service reconfiguration before concluding that patients have benefitted, in the round, from continued local availability of these services.

<sup>24</sup> For example, a similar proposal to reconfigure services proposed by the PCT and SHA, but for East Sussex, and was rejected by the Independent Reconfiguration Panel so did not proceed.



to improve services through changed processes, as well as differences between Trusts in the groups of clinicians most willing to collaborate and integrate following a merger. These issues are discussed further in Section 6.

90. In terms of outcomes, Barts Health told us that it had been able to reduce length of stay from 20 to 14 days for stroke patients across the Trust as a result of implementing a common care pathway. Western Sussex told us that the standardisation of antibiotic prescribing and infection control isolation policies across the Trust had been instrumental in reducing *Clostridium difficile* (C. Diff.) infection rates to the point that it now has one of the lowest incidents of this infection in the South East compared with the pre-merger situation where the two merging Trusts were among the worst performers in the area. In another example, Western Sussex told us that process improvements for patients with broken neck of femur had reduced the HSMR<sup>25</sup> (averaged over a 12-month period) for this patient group from 136.9 to 90.0 over the four years 2011 to 2015.<sup>26</sup>
91. As with the service centralisation changes described in the above section, the patient-centred clinical benefits arising from process improvement were also accompanied by positive financial impacts. In particular, we were told that reduced length of stay generated financial benefits for the Trusts, and where standardisation in a care pathway resulted in the adoption of common surgical inputs (e.g. hips or knees) savings on procurement could also be realised (although these were not generally considered to be significant savings in the context of Trust turnover, these savings were considered important at a department level, see paragraph 45).
92. The speed with which a Trust can realise the gains from process improvement will depend on the extent to which there is a clearly superior operating model that can be rolled out following a merger, or whether a longer process of clinical engagement is necessary to identify the process improvements that need to be adopted. As discussed in Section 6, however, there are probably only limited circumstances in which it is possible for an acquiring Trust to effectively impose its own operating model on an acquired Trust (that is where one Trust is clearly dominant and acquiring the other with the purpose of rolling out its operating model).

#### *Estate and infrastructure investment*

93. In each of the acute Trust case studies, there were investments in estate and infrastructure that were attributed to the merger by the Trust. In at least two of the mergers, a financially stronger Foundation Trust acquired an NHS Trust with a history of much weaker financial performance (Hampshire and Central Manchester) and accumulated reserves (in the case of Hampshire) were available for investment in the acquired site. In other cases,

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<sup>25</sup> HSMR is an acronym for Hospital Standardised Mortality Ratio and is a ratio of observed to expected number of deaths in a hospital. The expected deaths are calculated from logistical regression models taking into account and adjusting for a case mix of: age band, sex, deprivation, interaction between age band and co-morbidities, month of admission, admission method, source of admission, the presence of palliative care, number of previous emergency admissions and financial year of discharge. A score of 100 indicates that the observed number of deaths matched the expected number. A score higher than 100 indicates that mortality is higher than expected.

<sup>26</sup> See Western Sussex Hospitals NHS Trust, *Quality Account*, 2011/12 and Western Sussex Hospitals NHS Foundation Trust, *Annual Report and Accounts*, 2014/15.



efficiencies in service delivery that were realised following the merger enabled investment (Nottingham and Western Sussex).

94. A&E reconstruction took place at Winchester Hospital, part of Hampshire, following its merger. Hampshire told us that it had spent £30 million of its financial reserves carrying out essential rebuild work following a fire that occurred immediately before the merger took place. Central Manchester has also invested into Trafford Hospital following the service changes that have occurred on that hospital site.
95. The extent to which these investments in buildings and other infrastructure can be directly attributed to the merger is discussed further in Section 5.

#### *Improved ability to recruit clinicians and managers*

96. Each of the merged Trusts told us that they had found it easier to recruit clinicians and managers following the merger. Several Trusts reported that persistent vacancies that had been experienced in the years prior to the merger were able to be filled post-merger, and other Trusts said that higher calibre applicants were attracted to the merged organisation compared to the recruitment experience prior to merger.
97. Birmingham Community, for example, reported that prior to the merger the three community health providers had a consistent vacancy rate of 20% for Health Visitors. Following the merger, the number of Health Visitors was more than doubled and all vacancies were filled. Similarly, Barts Health told us that Whipps Cross A&E had 2 permanent consultants prior to the merger, but after the merger a full complement of eight permanent consultants was recruited. Hampshire also told of positive experiences of recruiting A&E consultants (replacing locums) at Winchester Hospital following its merger.<sup>27</sup>

#### *Increased ability to carry out Research and Development*

98. Nottingham and Barts Health both told us that their mergers had improved their ability to carry out Research and Development activities.
99. Nottingham told us that it was awarded three biomedical research units by the National Institute of Health Research (in audiology, respiratory medicine and gastroenterology) following the merger, more than any other acute Trust in England at that time. It said that the merged Trust was able to more quickly and effectively forge an agreement with the University of Nottingham to pursue these centres than would have been the case if the two Trusts had remained separate. It told us that patients had benefitted from the presence of these research centres at Nottingham through the early adoption of new treatments as well as the positive effect that these research units have had on the recruitment of high calibre clinicians to the Trust.

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<sup>27</sup> This improvement in recruitment outcomes for the merged Trust, however, may come at the expense of staff retention at other Trusts. It was not clear from the case study Trusts whether the reduction in long-standing permanent vacancies was a result of staff moving from permanent positions in other NHS Trusts (and possibly leaving behind unfilled vacancies).



100. Barts Health told us that a larger combined catchment area had resulted from its merger and given it an improved ability to identify patients suitable for participation in clinical research trials which had boosted its ability to carry out Research and Development.<sup>28</sup>

*Post-merger service performance*

101. Service performance, as set out in Section 3, was a motivating factor for several of the case study mergers. At Hampshire, we were told that there were concerns that Winchester Hospital's persistent financial problems were feeding into service performance issues (e.g. its ability to achieve waiting time targets).
102. At Western Sussex, concerns about the ability of the merging Trusts to adequately staff Emergency Surgery, Consultant-led Maternity and Paediatrics services had motivated the service reconfiguration proposals proposed by the SHA and PCT, which had been the event leading to the parties to decide to merge. We were told by the ex-commissioner for North East London that concerns about how to best provide efficient and safe health care services to the population in North East London had underpinned the Barts Health merger.
103. Further, once the mergers at Central Manchester and Western Sussex took place, significant service performance concerns came to light at Trafford Hospital and Southlands Hospital respectively. Both Trusts told us that the high HSMR at these hospitals was a concern for regulators shortly after the mergers took place and the Trust executives needed to prioritise actions to resolve the underlying causes of poor performance.
104. As set out above, the service concerns at Trafford and Southlands were primarily addressed by the newly merged Trusts through relocating the services with poor performance to alternative sites and applying improved processes for patient treatment. (All inpatient services moved from Southlands Hospital to Worthing Hospital, and the A&E and associated intensive care services at Trafford were moved to Central Manchester Hospital.) Hampshire was able to address waiting time issues and A&E performance at Winchester Hospital, in part, through the enhanced ability to recruit clinicians that it experienced post-merger.
105. More generally, Western Sussex is now ranked 60 out of 141 acute Trusts in terms of its HSMR performance, a significant increase on its 2011 ranking of 112<sup>th</sup>, which it attributes to the service changes and process improvement measures it has put in place since the merger. Barts Health, however, has struggled to improve services in the aftermath of its merger, and was placed in special measures in March 2015 following CQC inspections at its Whipps Cross, Newham and Royal London Hospital sites.
106. In summary, the case studies show examples of how, following a merger, the new Trust has successfully delivered improvements to services. In some cases, these improvements have led to improved patient outcomes or other measures of performance for either individual services or for the Trust overall, when compared to the pre-merger situation at

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<sup>28</sup> As with improved staff recruitment, it is not clear that ability of one Trust to carry out additional Research and Development activities necessarily represents a net improvement for patients. For example, the biomedical research units that were awarded to Nottingham may instead have been awarded to another institution, and this research would still have been carried out, but simply in another setting. In the context of a merger assessment it would be challenging to identify the factors that would suggest that this is a likely improvement to patients arising from a proposed merger.





one or both of the Trusts. In Section 6 we consider the factors that appear to be relevant to the successes some Trusts have achieved in securing post-merger service improvements.

107. Comparing planned with realised benefits is not straightforward as the level of detail in merger planning varied between mergers, and as a result, the level of specificity regarding the benefits that would be achieved post-merger also varied. At least to some extent the detail of intended service changes also tended to be conservative rather than potentially breach legal consultation processes. That said, service consolidation was clearly anticipated at both Central Manchester and Nottingham prior to the merger, and subsequently achieved.<sup>29</sup> Similarly, at Birmingham Community, the roll out of various services across Birmingham was planned prior to the merger, and successfully implemented. As set out above, several other benefits were not anticipated at the time of the merger (e.g. research and development at Nottingham and service consolidation at Western Sussex).
108. While process improvement was anticipated in several cases, the degree of planning and certainty over how this achieved varied, with Central Manchester having a much more detailed approach compared with, say, Western Sussex.<sup>30</sup>

## **5. How merging contributed to the realisation of post-merger benefits**

109. This section discusses the extent to which the benefits realised by the case study Trusts post-merger (and which are described in Section 4) were attributable to the merger. In particular, this section seeks to distinguish between those benefits:
- where the merger was necessary for the benefit to be realised, and there was no conceivable way it could have been achieved by the pre-merger Trusts (e.g. due to changes in the scale of the merged organisation);
  - where the merger contributed to the realisation of the benefit (e.g. through facilitating a change in management approach), but where it could also have been achieved – in principle – through actions or interventions other than a merger;<sup>31</sup> and
  - that arose from ‘business as usual’ initiatives that would have been implemented regardless of the merger.
110. While interviewees were positive about their merger’s contribution to the realisation of post-merger benefits, as will be seen in this section, it has been difficult to distinguish, with confidence, between the three different sources of post-merger benefits set out above. One reason for this difficulty is the longer timeframe over which service improvements, for

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<sup>29</sup> As noted at paragraphs 62 and 63, the scale of the service change was quite significant in these cases, although each merged Trust had very different approaches to planning. Central Manchester’s board made it a condition of merger that its executive team had a detailed and agreed approach with commissioners on the scale and method of implementing change. Nottingham, in contrast, had a general ambition to improve and focused on building clinical team working and culture over time, before effecting change.

<sup>30</sup> As noted at paragraph 74, in the case study of Western Sussex the plans for service change only came about over time and in the main, as a result of information and assessment of services post-merger. There was limited pre-merger planning for service change in this case study largely due to the circumstances and limited time frames within which the merger was concluded.

<sup>31</sup> A certain benefit may, in principle, be achievable in some way other than through a merger, whether this is the case in reality will depend on the specific circumstances of the merging Trusts. For example, where two Trusts have been seeking without success to achieve a particular benefit for some time through cooperative measures, then it may be that for those two Trusts a merger is the only conceivable way of achieving that benefit.



example, are achieved following a merger, and the number of other factors arising in the intervening period which also influence the realisation of these benefits.

111. Nevertheless, by distinguishing between these types of benefit it is possible to draw some general conclusions about the extent to which mergers may be necessary to deliver certain benefits, and also to start comparing mergers to other interventions that could also drive improvements in efficiency or service quality.<sup>32</sup>
112. This section, first, discusses the financial savings, and then the service improvements, identified in Section 4.

## 5.1 Financial savings

113. The post-merger financial savings achieved by the case study Trusts, were categorised as follows in Section 4: corporate overhead savings; clinical support savings; workforce savings; clinical service delivery savings; and estate and infrastructure savings. This section discusses whether the savings in each of these areas were dependent on the merger, or could have – in principle at least – been achieved in some other way than through a merger.
114. *Corporate overhead savings*: corporate overhead savings can be further sub-divided into those savings that arise from the implementation of a unified senior management structure (e.g. Board, Chief Executive, Finance Director, Medical Director, Chief Nurse etc.); consolidation of back office functions, like HR, finance, IT and estates management; and procurement processes (e.g. purchasing clinical supplies) (see Section 4).
115. Across these three areas within corporate overhead savings, only a merger could deliver the cost savings that arise from a unified Board and management structure. However, it is possible that for the cost savings that arise from consolidation of back office functions and procurement processes to be achieved (or at least a portion thereof) without a merger. For example, shared service arrangements between Trusts covering areas like HR, finance and payroll could deliver at least some of the savings from reduced corporate overheads without there needing to be a merger. As a result, these latter savings may be better regarded as having been facilitated by the merger, rather than being dependent on the merger.
116. *Clinical support savings*: savings that arise from unified management of clinical services across a merged Trust are dependent on the merger, and it is likely that savings in support functions like infection control teams and clinical governance functions can only be achieved with a merger. Other clinical support savings in areas like pharmacy and pathology are likely to be less dependent on a merger. In pathology, where several Trusts have entered into cooperative arrangements outside of organisational merger, there is likely to be little merger dependency.
117. *Workforce savings*: as set out in Section 4 (paragraphs 52 to 57), post-merger workforce savings in the case study Trusts arose from: harmonising job roles and pay grades across a new larger organisation; harmonising consultants' terms and conditions; reduced

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<sup>32</sup> These other interventions range from specialty specific initiatives to interventions in relation to Trust management (e.g. appointing turnaround directors) as well as the special measures and Trust administration regimes.



expenditure on temporary staff; and in one case, a generalised reduction in workforce numbers.

118. Savings from harmonising job roles and pay grades as well as consultants' terms and conditions require a merger to be implemented. This is because the merger is necessary to address the underlying conditions that resulted in pay grade inflation in the first place (e.g. one of the Trusts needing to pay more to attract staff because it cannot offer other non-pay benefits of being part of a larger Trust such as training, exposure to more varied or specialist work, or more comprehensive out-of-hours working arrangements). Similarly, where attracting permanent staff has been dependent on creating a larger, more attractive organisation to work for, then it follows that the savings arising from reduced expenditure on temporary staff are also dependent on the merger.<sup>33</sup>
119. *Clinical service delivery savings:* the dependence, or otherwise, of changes in clinical service delivery (e.g. service consolidation or clinical process improvements leading to shorter length of stay) following a merger that deliver service improvements as well as financial savings is discussed further in the following section. We conclude that in most cases mergers can play an important part in facilitating these benefits (that is, the resources the newly merged Trust can bring to bear to enable benefits to be identified and or realised more quickly than if a Trust remained independent).
120. But, there are rarely circumstances in which there is not some other way of also achieving these changes (e.g. through supporting a programme of clinical improvement to achieve similar improvements in patient outcomes). Whether alternative ways for achieving these benefits are capable of being successfully implemented by the merging Trusts without a merger will depend on the individual circumstances of those Trusts.
121. *Estate and infrastructure savings:* savings from a reduced property footprint are only achievable where services are moved away from a site. The extent to which this is dependent on a merger follows on from the extent to which service consolidation is dependent on a merger. As a set out above, mergers can play an important role in facilitating service changes, but there are rarely circumstances in which it is not – in principle – possible to achieve similar service changes without a merger.

#### *Summary of financial savings dependency on merger*

122. Within corporate overhead, clinical support and workforce savings, there are components that are completely dependent on a merger. However, within each of these areas the case study Trusts achieved savings that might also have been achieved without a merger. Savings arising from changes in clinical service delivery, in most cases, were facilitated by the case study mergers but could, in theory, have also been achieved without these mergers, although this is not to say that they necessarily would have been achieved in the absence of merger.

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<sup>33</sup> In the one instance of a Trust-wide reduction in workforce numbers as part of a cost savings programme implemented following a merger, that merger facilitated the carrying out of this cost reduction programme through the change in management approach brought about by the merger. However, the merger should probably be viewed as having facilitated this programme rather than being the only way in which that particular programme could have been carried out as this workforce reduction was unrelated to any change in service delivery and could have been achieved through the pre-merger organisations removing clinical posts in the same way (see paragraph 65).



123. It is not possible to estimate the proportion of total cost savings reported in each case study merger that were dependent on the merger and that those that were facilitated by the merger (but might have also been achieved in other ways without the merger). This is not least because of the difficulties of estimating the overall cost savings arising from the case study mergers (see paragraphs 65 and 66).
124. However, for those financial savings that came about through corporate overhead and clinical support savings (which we broadly estimate at 1-3% of turnover), it would seem reasonable to suggest that perhaps around half of these savings could be regarded as dependent on the merger. This view is based on both the discussion set out above, which looks at the different components of these savings, and takes into account the experience at the case study Trusts.<sup>34</sup>

## 5.2 Service improvements

125. This section discusses the five ways in which the case study Trusts realised service improvements following their mergers and the extent to which the realisation of these benefits was dependent on the merger. These service improvement measures were: service consolidation; process improvement; investment in estates and infrastructure; improved ability to recruit staff; and increased research and development (see paragraph 72).

### *Service consolidation*

126. Where decisions on the consolidation of services are for commissioners (subject to public consultation and other legal requirements), then decisions relating to service relocation or consolidation cannot be completely dependent on a merger. It will always be possible for a commissioner to decide to consolidate or relocate services without there needing to be a merger for this to happen.
127. That said, a high degree of consensus between commissioners, providers and the public is needed for large scale service changes to be achieved, and to the extent that a merger between providers assists in building that consensus, then a merger can make service changes much more likely to happen. Further, many of the service consolidation decisions in the case study Trusts did not require a formal consultation process, and were a matter for providers to decide.
128. Executives at the case study Trusts explained that a merger can align incentives and internalise revenue and cost impacts within a merged Trust so that it is much easier for service changes to be implemented.
129. The experience of West Sussex shows how a merger can assist in building a consensus for service change. Prior to the merger, the then PCT had sought to consolidate

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<sup>34</sup> At Birmingham Community, shared service arrangements were in place prior to the merger (at the two acquired community health providers), and savings of 1% of turnover were realised, while at Hampshire such arrangements were not in place, and savings of 3% of turnover were realised. (At other case study Trusts estimates of post-merger cost savings also include more significant contributions from non-comparable service delivery changes.) This comparison could suggest that around half of post-merger savings in corporate overhead are dependent on the merger, while the remainder could be realised from shared service arrangements. This is, however, a very high-level estimate, and does not take into account factors such as the different service profiles of these organisations, and the different mix of savings achieved by these organisations in these figures.



Emergency Surgery, Consultant-led Maternity and Paediatric services at one of the two pre-merger Trusts. These plans, which ran into significant public opposition, ultimately led to a decision by the Trusts to merge (and avoid the commissioner-led proposals, see Section 3). Subsequent to the merger, the new Trust has been able to build a clinical consensus around the best way to provide services, and this has allowed service consolidation to proceed more smoothly.

130. In Nottingham, another case study Trust where substantial consolidation of services has taken place post-merger, the Nottingham acute services strategy, which sought to reduce duplication across the two Trusts in Nottingham prior to the merger, was only partially successful. Trust executives told us that, in theory, it may have been possible to deliver some of the service changes that were implemented post-merger without the merger, but they do not believe this would have been achieved without the merger.
131. The Nottingham Chief Executive believe that the single management structure brought about by the merged Trust was key to aligning organisational objectives and making decisions in a timely manner. He explained that the single controlling mind of clinical leaders within teams means that clinical arguments to maintain status quo are minimised, and less likely to be used to circumvent or delay a more integrated clinical approach supported by the majority of clinical opinion. This point was repeated at all of the case-study Trusts that had successfully consolidated services and improved patient outcomes (Western Sussex, Hampshire, Birmingham Community, and Barts Health).
132. Notwithstanding this, several of the post-merger changes to services that were observed at the case study Trusts would have happened in any event. For example, it seems likely that the high HSMR that emerged at Trafford at the time of the merger with Central Manchester would, in the absence of that merger, have also resulted in the same, or a similar, change in where services were delivered from (and by whom). Nevertheless, the commissioner in Manchester explained that the merger was the most efficient and timely way for them to deliver the scale of change necessary to address their concerns regarding clinical outcomes and financial balance.
133. In Western Sussex, the contribution of the merger to the decision to remove inpatient services from Southlands Hospital is not entirely clear. Trust executives told us that HSMR rates at Southlands Hospital were relatively high before the merger, and while it seems likely that action would have been taken sooner rather than later to address this (e.g. following a CQC inspection), the merger – and the new management team that resulted from the merger - appears to have created the impetus and the urgency to have these issues addressed as a priority.
134. The ability of the new management team to address the mortality issue at Southlands Hospital through the relocation of inpatient services from Southlands Hospital to Worthing Hospital was also assisted by several factors related to the merger. In particular, capacity at Worthing Hospital needed to be created for the inpatient service (approximately 120 inpatient beds), and this was achieved by relocating the elective hip and knee surgery from Worthing Hospital to St Richard's Hospital (the third hospital and introduced by the merger). The merger enabled the services to be reconfigured across the three hospital sites more easily because each of these services generate different revenues that we were



told would have been very difficult to balance between the two pre-merger organisations (i.e. one of the pre-merger Trusts would have experienced a net financial loss from the service changes).

135. In summary, where service consolidation was delivered in the case study mergers, a number of common themes enabling the service change, and related to the merger, can be identified:
- A merger can galvanise the clinical and managerial action at a provider level that is necessary to deliver significant changes to services in a timely manner by focusing attention and resource on the implementation of service change.
  - Patient services that are suffering major quality problems are likely to be consolidated with strongly performing services, where appropriate, to access the best available clinical resources within a geography, and financial (as well as other organisational measures and objectives) can be more easily aligned following a merger (where the organisation and its objectives are, by definition, the same).
  - A merger can help in promoting cooperation between clinicians to enable necessary changes to the delivery of services to be successful and take place more quickly because the clinical leadership can be more easily aligned within a single organisation than between two organisations. However, there is no certainty that clinical alignment will necessarily happen post-merger (and Section 6 discusses instances where this has, and has not, been successful).

#### *Process improvement*

136. The three case study Trusts that have had the largest programmes of process improvement following their merger were, as set out in Section 4: Western Sussex; Birmingham Community; and Central Manchester (see paragraphs 88 to 95).
137. In each of these case studies, the merger was the spur that led to the process improvement activities being undertaken (implementation of Central Manchester clinical policies at Trafford; adoption of improved antibiotic prescribing, elderly care admissions and infection control isolation policies at Western Sussex; and for Birmingham Community across its entire service portfolio).
138. Executives at the case study Trusts told us that without the merger the pre-merger providers would have continued to deliver services in the same way because there was no managerial or clinical reason to initiate change. Management changes or partnerships with other providers, where these had been trialled pre-merger, had not provided the same 'shock' that had occurred as a result of merger.
139. Both Nottingham and Western Sussex told us that they did not believe that it would have been possible for the pre-merger Trusts to have achieved the same process improvements without the merger. In both cases, Trust executives said that they considered that the merger allowed management of the merged Trust to direct staff to comply with new processes, and was not as reliant on voluntary cooperation as is the case with a partnership or other collaborative arrangement.





140. We were also told that a merged Trust was able to take decisions at a quicker pace in terms of identifying and adopting revised processes than under a partnership or alternative arrangement. Western Sussex said that as a larger Trust it had the resources available to pursue process improvement in a way that was not achievable with a smaller Trust where the number of clinicians in each specialty was much smaller. Finally, in both of these cases commissioners had over a period of years preceding the merger attempted to instigate change at the pre-merger Trusts without significant impact (in the case of Western Sussex through the process of a full reconfiguration review and public consultation process).
141. In general, without reviewing the experience of implementing process improvement at other Trusts where mergers have not occurred, it is difficult to draw a meaningful conclusion about the extent to which a merger is necessary for process improvement to take place.
142. As a result, these case studies suggests that a merger can initiate the clinical and managerial action at a provider that is necessary for process improvement activities to take place. In some circumstances it may also be possible that a merger is the only way for this to occur (and some of the executives at the Trusts we interviewed believed that this was the case), but we do not consider that it is possible to be definitive on this point without additionally reviewing examples of situations where process improvement has taken place (or been attempted) without a merger.

#### *Estate and infrastructure investment*

143. New investment in estate and infrastructure can be dependent on a merger where the transaction allows access to capital from a financially stronger partner. For example, the Hampshire Hospital transaction is an example of this. In this case, Basingstoke was not provided with additional funds from commissioners to undertake investment in Winchester's estate, and its own financial reserves (approximately £30 million) were used to fund necessary estate maintenance, and to rebuild the A&E department. It is possible that capital may have been made available to Winchester Hospital through other means absent a merger (e.g. through commissioner or direct Department of Health support), but we were told that there was no obvious route for this.
144. New investment in estate and infrastructure can be dependent on a merger where the transaction allows efficiencies to be realised that can then be used as the basis for financing infrastructure investment, or where a larger balance sheet and stronger cash flow than at the individual constituent Trusts permits increased borrowing (while remaining within Monitor's financial guidelines).<sup>35</sup>
145. Of the case study Trusts, Western Sussex appears to be an example of where investment in the merged Trust's estate (in this case at Worthing Hospital, which has an estate dating back to the 1960s) was possible as a result of the greater financial resources within the

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<sup>35</sup> We were not told during our interviews with the case study Trusts of any examples where the merger had enabled greater borrowing for investment into estate. However, it was an objective within Bart's Health financial plans prior to the merger that annual repayments for earlier borrowing under a Public Finance Initiative (PFI) investment would return to within 12% of turnover as required by Monitor financial governance guidance.



control of the merged Trust. This can, in turn, deliver benefits to patients as poorly maintained estate can lead to poor infection control (see Section 4).

#### *Improved staff recruitment and increased research and development*

146. It was the unanimous view of the case study executives we spoke to that improved staff recruitment was linked to the merger, with larger organisations generally more attractive to potential employees (especially clinical employees) as a result of being perceived as being able to offer better training, career development opportunities, and interesting / challenging clinical workload experience. In Section 4 (see paragraphs 99 and 100) a number of examples of where recruitment challenges had been overcome following the merger are discussed.
147. In the view of the Trust executives that we spoke to, research and development arising from biomedical research units awarded to Nottingham and Barts Trusts is likely to have been facilitated by the merger in both cases. However, it is less clear that the merger in each case was a determining factor leading to additional research and development activity as a whole (as opposed to additional research and development activity taking place at that particular Trust).

#### *Summary of service improvements*

148. Each of the service improvement measures reviewed in this section could, in principle, take place without a merger. Service consolidation, process improvement, and investment in estate and infrastructure can all take place without requiring a merger. Further, in relation to improved staff recruitment and increased research and development following a merger, it is not clear that there has been a net overall benefit for patients and commissioners.
149. Nevertheless, case study Trust executives were clear in their view that their merger at the very least facilitated the delivery of these benefits given the particular circumstances faced by their organisations. Further, we were told that in all of the case studies these benefits were achieved more quickly than if the Trusts had not merged, or merged with different organisations. In each case study it was explained that the merger in question followed a decision making process that involved evaluating alternative options, including different merger partners, and timeframes for delivery of these benefits. As a consequence, the executives and commissioners were confident that there were no obvious alternatives at the time of the merger that were likely to have delivered these particular benefits.
150. As a result, there seems to be a strong case to regard the mergers as having played an important role, at the very least, in facilitating the delivery of these benefits at the case study Trusts, and that without these mergers, these benefits may well not have been achieved by the Trusts in their standalone form, or may have only been achieved more slowly.<sup>36</sup> However, this does not mean that it is possible to conclude that a merger will always be a necessary facilitator of particular service improvements at merging Trusts.

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<sup>36</sup> One likely exception to this general conclusion relates to those service improvements prompted by requirements for urgent action to improve patient care at Trafford and Southlands Hospitals. In the absence of the merger, services at these sites may have been subject to a commissioner or other regulatory organisation imposing change upon the health care providers to ensure service improvement (as discussed in greater detail above).



Whether a merger is necessary to facilitate achieving service improvements will be the case will depend on the circumstances facing the Trusts involved, and in particular, whether there are factors present that make alternative options for achieving these service improvements unfeasible.

## **6. What are the common factors when merger benefits are realised?**

151. All of the case study Trusts were successful in realising the financial benefits available from integrating corporate overhead functions, and certain clinical support savings. Each case study Trust was also successful in achieving other benefits from their merger, such as being able to consolidate services, implement process improvements, or appoint permanent staff to persistent vacancies. Nevertheless, some case study Trusts experienced greater success than others in realising benefits that go beyond integrating corporate and clinical support functions. This section identifies and discusses the factors that appear to have played a significant role in determining whether a Trust was able to achieve a particular benefit (and, where relevant, factors that hindered achievement of a particular benefit).
152. Three factors that appeared important in successfully implementing multiple measures that contributed to achieving efficiency and service improvement benefits were:
  - *Having detailed plans pre-merger for post-merger operations:* including new organisational structures, operating models, and location of services. (Hampshire, Birmingham Community, and Central Manchester were examples of where Trusts had developed detailed plans for these aspects of change prior to their merger.)
  - *Encouragement and support for clinical leadership post-merger:* including unified management of clinical service areas, joint governance arrangements, and clinical leadership in close touch with operations on all sites. (Western Sussex, Hampshire, and Birmingham Community Trusts were good examples of organisations that focused on these aspects of merger integration.)
  - *Ongoing and clear staff engagement post-merger:* including decision-making that did not favour (or be seen to favour) one of the pre-merger Trusts, clear and consistent vision, regular communications with staff, and management appointments that are not seen to favour one of the pre-merger Trusts. (Hampshire, Nottingham, Birmingham Community were good examples of organisations that focused on these aspects of merger integration.)
153. There were also other factors, such as the presence of financial reserves at Hampshire to deliver improved estate, and commissioner support for the service changes at Trafford that were important to achieving specific post-merger benefits. However, these had less commonality across the case studies.
154. The case study Trusts were typically stronger in some of these areas than others. For example, Central Manchester in acquiring Trafford had detailed plans for the post-merger organisational structure, the operating model that would be applied to service provision at Trafford (i.e. Central Manchester's own model), and the range of service changes that



would be enacted following the commissioner consultation process. Central Manchester's strength in this area, the authoritative clinical leadership it was able to deploy, and its managerial capacity to implement its plan, meant that progress could be made more rapidly, and the effect of resistance to change in some service areas could be minimised in comparison to the broad-based clinical consensus several of the other case study Trusts needed to first achieve before attaining planned benefits from merger.

- 155. On the other hand, both Western Sussex and Nottingham had a strong focus on clinical leadership and engagement post-merger from which detailed service improvement plans could emerge.
- 156. These three common factors are discussed further in the remainder of this section.

### **6.1 Detailed plans pre-merger for post-merger operations**

- 157. Those Trusts that had, pre-merger, developed detailed plans for their post-merger organisational structure were able to move swiftly to formally consult on their planned structure and commence the processes necessary before implementation, and the associated cost savings, can be achieved. Hampshire and Birmingham Community are both examples of mergers where the management team for the newly merged Trust were able to announce the planned organisational structure on Day One. This allowed the required staff consultation processes to start with the maximum amount of certainty for staff, which helped minimise the negative impact of a process that executives commonly described as difficult and painful. Pre-planning was more important to the successful delivery of improvements for those transactions which were a 'merger of equals' (see Section 3).
- 158. Central Manchester, as discussed in Section 5, was the stronger merger partner and had an operating model to roll out for clinical service delivery at Trafford, and a clear plan for how services would be changed and relocated across its hospital sites. This detailed operational planning allowed a rapid transition to the new service arrangements at Trafford in terms of the scaling back of services (following the commissioner-led consultation), and the implementation of improvements that were considered necessary by Central Manchester for services delivered from its new Trafford sites. (As set out in Section 5, however, Central Manchester took longer than some other Trusts in integrating clinical support functions because of the broader impact on existing Central Manchester staff during the HR consultation process.)
- 159. Similarly, Birmingham Community, a merger of three similarly sized Trusts, had a clear plan for rolling out certain key services Birmingham-wide following the merger (Rapid Response Teams and IV Therapy at Home), and these changes were implemented within the first 12 months of the merger.
- 160. Hampshire also had a clear plan for how services should be delivered post-merger based on the construction of a new critical care hospital, and the centralisation of services from both Winchester and Basingstoke at this site. Implementation of these plans has not, however, been achieved due to a loss of commissioner support post-merger (discussed further below).



161. Western Sussex and Nottingham, both mergers of similarly sized Trusts, had little by way of detailed post-merger service delivery plans, but both have still achieved significant benefits over a longer period of time as a result of the strength of the clinical and staff engagement that was instead focused on and built up in the period immediately following merger – discussed below.

## **6.2 Strong clinical engagement post-merger**

162. Having clinicians from different sites working together was emphasised, across almost all of the case studies, as critical for the merged organisation in identifying, agreeing and implementing improvements to the way in which services are delivered.
163. This was particularly the case for those mergers where the transaction was a coming together of equals (Nottingham and Western Sussex). Even where the transaction was not a merger of equals (Birmingham Community and Barts Health) the achievement of clinicians working together as a single team from across the merged Trust was recognised as a key ingredient in achieving success and improved patient outcomes from clinical services.
164. Each case study Trust demonstrated that there were positive actions that a newly merged Trust could take to facilitate effective, cooperative working between clinicians, and we discuss these factors in the following paragraphs. In some cases, these positive actions were reinforced by favourable external circumstances. However, executives and clinicians from the case study Trusts also told us of actions that made it less likely that clinicians (and other staff) would work cooperatively together. Where teams remained separate this generally reduced the likelihood that productive working relationships would develop and lead to new ideas and an internal clinical consensus about the best way to deliver services across the merged Trust.
165. An important starting point for the case study Trusts, immediately following merger was to establish clinical leaders within each specialty. Hampshire, for example, explained that following an open appointments process they encouraged and expected the lead clinicians to take full responsibility for the operations and patient outcomes from their divisions. Other case studies (Barts Health and Nottingham) explained that where exceptional clinical leaders had been appointed then significant change and service improvements had followed. Western Sussex told us that it established joint governance meetings for clinicians to conduct morbidity and mortality reviews immediately following the merger, as well as encouraging regular service performance discussions more generally (again led by the clinicians as and when appropriate) and these seemed to be important in building effective clinical engagement with the opportunities for improvement following merger.
166. Some of the case study executives we spoke to would have preferred to have initiated joint-clinical working prior to Day One of the merger. Central Manchester executives, for example, told us that if they had been able to have their own clinicians on-site to better understand day-to-day clinical practice and incident reporting at Trafford they could have been better prepared to plan and implement immediate strategies from Day One of merger, when they became clinically and legally accountable for patient outcomes. We were told that this would have, in their view, reduced the clinical and legal risk of acquiring the services at Trafford. We were told that given the background to the merger there was



some resistance from some Trafford staff that prevented comprehensive joint-working prior to the merger. Central Manchester executives were strongly of the view that closer clinical working, in the pre-merger period, would have achieved a safer handover of services and that Monitor could investigate further the extent to which pre-merger working might be permitted and encouraged when developing guidance for future merger transactions.

167. Effective clinical leadership in a multi-site Trust clearly has its challenges, and we were told during the case study interviews that these challenges increase with the number of sites and the distance between them. Barts Health told us that having established a completely specialty-based leadership structure with responsibility across all five of its sites, it had reviewed this model, following CQC guidance, and was now strengthening its site-based management. This was because day-to-day travel between the sites by managers had proved difficult and resulted in service directors travelling significantly but having insufficient time to maintain strong relationships with operations staff. Hampshire told us that they had reviewed their clinical management structures in the time since they were first established and had decided to strengthen site-based management to reduce the daily travel requirements travel and enable day-to-day management operations to proceed in a timely way (e.g. bed management and staff rostering). The capacity of the Trust executives to revise and support management structures to ensure clinicians have adequate support is also a factor that was perceived to enhance the success of implementing a merger.<sup>37</sup>
168. Western Sussex told us that it had addressed the problem of having two main sites (St Richard's Hospital and Worthing Hospital) that were 20 miles apart by: (i) requiring its clinical leaders to undertake clinical work at each site, so that they remained in close touch with all of their clinical colleagues, and were familiar with the day-to-day issues associated with practising on each site; and (ii) designed job plans such that intra-day travel between the two sites was minimised.
169. Nottingham told us that a single clinical management structure was a key part in the process of aligning objectives, and making decisions in a timely manner. The "single controlling mind" also avoids much of the competition that naturally exists within and between clinical teams from different Trusts (and hospital sites). Western Sussex told us that the naturally competitive nature of its consultants had been helpful in generating momentum for change. We were told that where consultants were presented with evidence that superior patient outcomes could be clearly linked to a superior patient pathway were being achieved by one site, then those consultants achieving lesser patient outcomes had an obvious incentive to adopt the demonstrated practice.
170. Even so, all of the case study interviews emphasised that the personal attitudes of clinicians were important, and that some clinicians were more amenable to collaborative working than others.<sup>38</sup> This meant that progress in terms of clinical integration at the merged Trusts across different specialties was variable. Nottingham gave us an example of where it was able to address a particularly problematic specialty by appointing new

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<sup>37</sup> It is likely that these adjustments to introduce management capacity at a service level would have had some impact on the financial savings achieved from these management changes. However, as noted at paragraph 48 the cost of these service structures is not likely to be a major component in the financial savings achieved from merger and have greater importance in the context of achieving service improvements from merger.

<sup>38</sup> While we received no direct evidence on this point, the extent of clinicians' willingness, as an entire group, to collaborate across a merged Trust is likely to be influenced by the effectiveness of staff engagement post-merger.





leadership to that specialty, but we were also told that in other cases it was accepted that the process of integrating teams would take longer, particularly if achieving clinical integration and change in that specialty was a lower order priority for the Trust (the interviews with Nottingham executives were held approximately nine years after the merger).

171. Those case study Trusts that were the product of a “merger of equals” told us of the importance of senior leadership appointments at the newly merged Trust being seen as not favouring candidates from one particular Trust over the other. Running a fair, open recruitment process for these positions was one way in which the new Trust was able to demonstrate that it was open to developing a new staff culture and listening to views from across the entirety of the new Trust. However, this may not be sufficient to address a perception of bias if all of the appointments resulting from this open process end up being from one of the merging Trusts. Barts Health explained that this factor had caused some difficulty and delay for executives when seeking to implement clinical and other changes following merger.
172. Western Sussex told us that the appointment of outsiders to the new Trust had been an important way to ensure that the new management team did not encourage a perception of either predecessor Trust being favoured after what had been a public competition, led by commissioners, for one Trust to “win” the role of being the major Trust for the region. We were told of the appointment of a new CEO and Deputy CEO who had each only briefly served (a few weeks) with the predecessor Trusts prior to being appointed at the merged Trust. In addition, the new Finance Director and Medical Director were both appointments made from outside the candidate pool of the two merging Trusts.
173. Investment decisions were also highlighted by Hampshire executives as a source of tension within the newly merged Trust. In that case study we were told that many of its staff at one site (Basingstoke) felt that they were losing something by investing ‘their’ financial surplus into estate development at Winchester (conversely staff from Winchester felt supported through these investment actions). In many mergers one site may be in more urgent need of investment than another, but we were told that the potential for this type of perception to hinder closer clinical and other staff working meant that it was a genuine issue that needed attention from the Trust management to assist staff to accept the wider role and catchment population of the merged Trust (e.g. creating opportunities for discussion and explanation). The need for the Trust executive to invest both time and resource over a long period of time (many years) into developing a single staff culture, especially in those mergers that were of ‘equals’ was emphasised in almost all of the case studies.
174. For those Trusts that were acquiring the other the rationale for the transaction is predominantly that the existing management team at a highly performing Trust replace the management of a less well performing organisation. With this approach comes an expectation that the acquiring organisation will be running the new, larger organisation. This was clearly the case in relation to Central Manchester’s acquisition of Trafford, and both the Birmingham Community and Hampshire mergers were also structured in this way. In these cases, having a clear plan for how to integrate the newly acquired Trust (or PCT



provider arms) and implementing the clinical processes that the newly acquired Trust will follow is a different route to achieving merger benefits.

### **6.3 Strong staff engagement post-merger**

175. Successfully engaging with staff across the newly merged organisation, and particularly with nursing staff, was the third factor that clearly came through from the merger case studies as a critical factor in the post-merger performance of a newly established Trust. From our interviews with Trust executives it was apparent that staff engagement is a core function of the executive team, but in the context of any recent merger it was explained to us that a key issue was to avoid creating disharmony between groups of staff (on different sites) or between clinical staff and management.
176. All of the executives we spoke to from the case study Trusts were clear that the employee adjustment process post-merger was painful and difficult. We were told that it is inevitable that this will be the case when the method to successfully realise the benefits of a merger will always involve job losses in administrative and support teams and changes (often significantly so) in the way clinical staff do their jobs and adjust to revised patient pathways.
177. We were told that the key to success is to focus management time on those positive actions that will minimise the time and significance of what was described as an inevitable decline in staff morale and performance post-merger. Further, we were told that where Trust executives and clinicians can either avoid negative programmes or undertake them quickly (in a planned and inclusive way) this will reduce the possibility of derailing the planned benefits of merger. We review some of the examples explaining these points and arising from the case studies next.
178. Birmingham Community executives told us that the staffing issues resulting from its merger were difficult and painful (i.e. staff resistance to change and the staff at risk process leading to some redundancies). However, the executives also explained that by maintaining and sharing with staff their vision for the Trust becoming an improved and better place to work, alongside delivering improvements for patients, there was a means by which the staff and organisation culture were brought together.
179. Birmingham Community executives explained that they would have liked to have offered staff (especially administrative staff with roles affected by the merger) greater certainty prior to the merger about how they were likely to be impacted by the changes. However, legal requirements around staff consultation in the lead up to merger restricted the degree to which executives could provide clarity about the likely impact of the merger on individuals. This period of uncertainty (which is impacted by the time taken to gain approval to merge) was managed in this case study by the executives explaining that there was a plan and that it would be shared on Day One of the merger (i.e. as soon as they were legally able to do so). The subsequent follow-up on Day One and all other interactions and communications post-merger were designed to build trust and dialogue between staff and management throughout the implementation phase of the merger plans.
180. Central Manchester and Barts Health both engaged in job role and pay grade harmonisation exercises post-merger, and in both cases we were told by the executives



that this necessary, but negative, process had a significant impact on nurse morale and retention.

- At Central Manchester, the impact of this process on the merged Trust was mitigated by: (i) Trafford Healthcare's small size relative to Central Manchester (the change in services provided from Trafford Hospital following the merger also reduced the impact on staff morale at Trafford from this harmonisation process i.e. a number of staff were made redundant); and (ii) staff at Trafford Hospital knew that the transaction was an acquisition rather than 'merger of equals' and expected significant change as a result of the merger.
- At Barts Health, the harmonisation of job roles and pay grades had a major negative impact on nursing staff at Whipps Cross and Newham, but without the mitigating factors that were present at Central Manchester. The executives we spoke to at Barts Health told us that significant and ongoing executive time had been spent explaining the need for the harmonisation of terms and conditions and its intended outcome. However, we were told that the harmonisation process was a significant factor behind the departure of many nurses from these two hospitals, and a consequent increase in the Trust's reliance on agency staff following the merger. When compared with Central Manchester, Whipps Cross and Newham formed a much larger proportion of the merged Trust (than Trafford did of Central Manchester) and as a result it seems that the negative impact of the harmonisation process was of much greater effect on the overall performance of the newly merged Trust. Moreover, the impact of the harmonisation exercise on nursing staff at Whipps Cross and Newham fed a negative overall narrative for staff that the merger was not one of equals, but was in reality at takeover by Barts and The London. This last point was explained to us by the executives at Barts Health as having made it more difficult for the Trust executive to lead its programme of planned merger benefits for the merged Trust.

181. Central Manchester also told us that nurse retention on the Trafford Hospital site was adversely affected after the merger by the uncertainty over the future of services at Trafford. Unfounded rumours of the facility closing did not help, but there was also an issue of the nursing staff having clarity over the type of work that would be carried out at Trafford, following the merger, and whether this was the type of work they wanted to be involved with. Trust executives said that it was simply a matter of time before the staff and public accepted and understood the portfolio of services provided from the site (i.e. following the commissioner-led consultation process) and once this was clear, and all the clinical leaders were in place, it became much easier to recruit nurses to work at the Trafford site. That is, nurses wanted to understand the scope of their role and who they were working with before they could evaluate working at Trafford Hospital against working at other hospital sites across Manchester. The Trust executives explained that the only delay in sharing the new 'brand' of Trafford Hospital was from the consultation process that began six months following the merger and that the nurse retention issues were resolved within two years of the merger.
182. Nottingham told us that the general reduction in nursing and other staff that it carried out immediately post-merger, as part of the financial balancing plan for the merged Trust, created a period of reduced morale among some of its nursing staff, and this took some



time for the merged Trust to fully overcome. The Trust executives that we interviewed explained that it would be unlikely that a similar non-specific role reduction across a merged Trust would be possible in the modern environment of closely monitored nurse to patient ratios and regulatory oversight.

#### **6.4 Other factors**

183. In addition to the three primary factors for achieving planned merger benefits set out above, two secondary factors came through in the case studies as key to post-merger benefit realisation. These were:
- having commissioner support for significant planned service changes; and
  - the existence of financial resources to deliver estate and infrastructure investment improvements.
184. The importance of commissioner support in the delivery of significant service changes was shown by the contrasting experiences of Central Manchester and Hampshire. In Central Manchester, clear and consistent support from commissioners was helpful in moving to public consultation in a timely manner following Central Manchester's acquisition of Trafford, and the subsequent local decision to change services at Trafford was achieved relatively quickly. However, despite this support and coordinated approach, the referral of the decision to the Secretary of State meant that the changes necessary to achieve safer patient outcomes and financial balance for the services provided from Trafford Hospital were delayed, and could not be fully implemented until the second year of merger.
185. By contrast, the change in commissioning structures in Hampshire, in the period shortly after merger, (i.e. the replacement of the former Hampshire PCT with two CCGs commissioning services) resulted in changed commissioning stakeholders and commissioning priorities. The consensus that the executives of Hampshire had thought was in place prior to the merger (in relation to the commissioning of a new critical treatment hospital between Winchester and Basingstoke) was lost. This loss of commissioner support has meant that Hampshire's preferred configuration of health care services has not been achieved. Hampshire is continuing to discuss and reach an understanding with its commissioners for how to achieve these merger benefits, three and a half years after merger.
186. Executives from Hampshire also explained how their financial reserves gave them a freedom to upgrade the estate at Winchester Hospital (in particular the A&E department) despite the change in commissioners following the merger. If this investment had been dependent on commissioner approval, then the Trust's ability to achieve this benefit would have been more difficult. (Winchester as a stand-alone Trust had been unable to prioritise the required investment over a long period of time prior to the merger with Basingstoke.) Central Manchester executives noted during interviews that investment into a redevelopment at Altrincham General Hospital had been supported by commissioners and the SHA (this investment was funded by the sale of part of the Trafford Trust estate prior to the merger proceeding). The executives noted that there was a degree of frustration from within the Trust about the constraints on its leadership and management of the development, and in particular the development timetable (the redevelopment was completed three years following merger).



## **6.5 Conclusion**

187. The relative importance for a merging Trust to focus on developing: (i) detailed post-merger plans ahead of completing the transaction; (ii) strong clinical engagement strategies for the period post-merger; and (iii) plans for how to deliver difficult messages to staff across the newly formed organisation, will to some extent be influenced by whether the merger is intended to bring partner organisations together or instead provide a basis for one organisation to take responsibility to deliver wholesale service change from an acquired organisation.
188. In a takeover model, where the intention is to extend the operating model of the stronger Trust to the weaker Trust, the most important factor will be the presence of clear and detailed post-merger plans that can be implemented from Day One of the merger (for example Trafford Trust). This merger model also seems likely to work best when the acquiring Trust is much larger, and is a significantly superior performer both financially and clinically than the acquired provider. If these conditions are not present, then bringing the clinicians and staff along with the executive plans for the newly merged Trust will play a more important role.
189. In a 'merger of equals' model, having strong clinical and broader staff engagement will be critical to delivering merger benefits (e.g. Western Sussex) because this is the way that clinical staff build a consensus for change. However, if engagement is not successful, then little by way of benefits can be achieved until a single organisation vision has been agreed and adopted by the newly merged Trust and its staff (e.g. Barts Health).
190. The case study mergers have shown how each of these models can be used to facilitate the achievement of clinical and financial post-merger benefits. The case studies also show that where a merger lacks clarity about whether it is an acquisition or a merger of equals and does not succeed in engaging with clinicians or the broader staff group, it is going to find securing any benefits from its merger difficult.

## **7. Summary**

191. In summary, it has been possible to identify efficiencies and service delivery improvements that were realised following the merger by each of the merged Trusts, although the extent of these benefits varied across the case studies. Savings in corporate overheads and clinical support services of around 1-3% of a merged Trust's turnover were generally realised relatively quickly post-merger.
192. Each of the merged Trusts also made service delivery improvements post-merger, and these were frequently accompanied by further cost savings. Service improvements arose from a variety of measures that were implemented post-merger, including consolidating services onto fewer sites with larger volumes, process improvement, and investment in estate and infrastructure. The case study Trusts most frequently engaged in service consolidation in relation to elective orthopaedic services. However, examples of service improvement were observed across a wide variety of specialties and care pathways.
193. Service improvements, and the accompanying costs savings, generally took longer to achieve than savings from the rationalisation of corporate overheads and clinical support



services (e.g. at least 2-3 years compared with 12 months). This was due to the greater complexity of these changes, and the need to ensure internal and/or external stakeholder support prior to implementation.

194. While interviewees were positive about their merger's contribution to the realisation of post-merger benefits, it has been difficult in relation to many post-merger service improvements to distinguish, with confidence, between: (a) those benefits that were enabled by the merger (and could not have otherwise been achieved); (b) those benefits that were facilitated by the merger (and were made easier to achieve as a result of the merger but could, in principle, have been achieved without the merger); and (c) those benefits that arose from 'business as usual' initiatives that would have been implemented regardless of the merger.
195. One reason for this difficulty is the longer timeframe over which service improvements are achieved following a merger, and the number of other factors arising in the intervening period which also influence the realisation of these benefits.
196. Several common themes emerge from the case studies in terms of those Trusts that experienced success in realising merger benefits. In particular: (i) the presence of detailed plans for post-merger operations; (ii) encouragement and support for clinical leadership and involvement in post-merger service planning and delivery; and (iii) clear, and ongoing, engagement with staff following the merger. The case studies frequently demonstrate a clear association between the 'soft skills' of leadership, and clinical and staff engagement which results from that, and the delivery of meaningful benefits to patients and commissioners.
197. The relative importance of these factors to the achievement of post-merger benefits often appears, on the basis of these case studies, to be linked to whether a merger could be characterised as either a 'merger of equals' (i.e. between Trusts of equal size and influence) or a 'takeover' where a stronger Trust acquires one or more weaker organisations.
198. In a 'takeover', where there is a clear understanding that the acquiring Trust will be applying its own operating model to the weaker Trust, then the presence of detailed plans for post-merger operations will be more important to ensuring that benefits from the merger are achieved (although not to the exclusion of effective clinical and staff engagement). However, in a 'merger of equals', clinical and staff engagement will be more important for identifying, and gaining support for (particularly from clinical staff), the adoption of common, improved, practices across the merged Trust that will underpin service delivery improvements (although not to the exclusion of needing to have plans for post-merger operations).
199. In either case, it appears that the quicker a merged Trust can achieve a single organisational vision and culture, the smaller the risk that merger benefits are not delivered. Risks to achieving merger benefits seem to increase (and the ability of achieve a single organisational vision) where management actions and messaging is inconsistent (e.g. describing a transaction as a 'merger of equals' when it looks and feels to staff like a 'takeover').





## **Appendix A – Interviewees for merger case studies**

### **Barts Health NHS Trust**

- Alwen Williams, Chief Executive Officer, Barts Health NHS Trust (at the time of merger, Chief Executive of NHS Outer North East London)
- Ian Walker, Director of Corporate Affairs and Trust Secretary, Barts Health NHS Trust
- Dr Alastair Chesser, Executive Group Director for Emergency Care and Acute Medicine, Barts Health NHS Trust
- Frances O'Callaghan, Director of Strategy, Barts Health NHS Trust

### **Birmingham Community Healthcare NHS Trust**

- Tracy Taylor, Chief Executive Officer, Birmingham Community Healthcare NHS Trust
- Peter Axon, Chief Finance Officer, Birmingham Community Healthcare NHS Trust
- Andy Harrison, Chief Operating Officer, Birmingham Community Healthcare NHS Trust
- Beverly Ingram, Director of Nursing & Therapies, Birmingham Community Healthcare NHS Trust
- Joanne Thurston, Director of Business and Organisation Design, Birmingham Community Healthcare NHS Trust

### **Central Manchester University Hospitals NHS Foundation Trust**

- Adrian Roberts, Director of Finance and Acquisition Project SRO, Central Manchester University Hospitals NHS FT
- Stephen Gardner, Project Director, Central Manchester University Hospitals NHS FT
- Cheryl Lenney, Chief Nurse, Central Manchester University Hospitals NHS FT
- Professor Robert Pearson, Medical Director, Central Manchester University Hospitals NHS FT
- Leila Williams, Director of Service Transformation, NHS England (North of England)



### **Hampshire Hospitals NHS Foundation Trust**

- Mary Edwards, Chief Executive, Hampshire Hospitals NHS FT
- David French, Chief Financial Officer, Hampshire Hospitals NHS FT
- Andrew Bishop, Chief Medical Officer, Hampshire Hospitals NHS FT
- Donna Green, Chief Operating Officer and Chief Nurse, Hampshire Hospitals NHS FT
- Heather Hauschild, Chief Officer, West Hampshire CCG (previously Director of Quality and Service Development, NHS Hampshire)
- Jane Hogg, Integration and Transformation Director, Frimley Health NHS FT (previously Programme Director, Hampshire Hospitals NHS FT)

### **Nottingham University Hospitals NHS Trust**

- Louise Scull, Chair, Nottingham University Hospitals NHS Trust
- Peter Homa, Chief Executive, Nottingham University Hospitals NHS Trust
- Dr Stephen Fowle, Medical Director and Deputy Chief Executive, Nottingham University Hospitals NHS Trust
- Tim Guyler, Acting Chief Operating Officer, Nottingham University Hospitals NHS Trust
- Andrew Fearn, Director of ICT, Nottingham University Hospitals NHS Trust

### **Western Sussex Hospitals NHS Foundation Trust**

- Marianne Griffiths, Chief Executive Officer, Western Sussex Hospitals NHS Foundation Trust
- Dr Mike Rymer, Non-Executive Director, Western Sussex Hospitals NHS Foundation Trust
- Dr Rob Haigh, Chief of Service, Division of Medicine and Deputy Medical Director, Western Sussex Hospitals NHS Foundation Trust
- Jane Farrell, Chief Operating Officer, Western Sussex Hospitals NHS Foundation Trust
- Denise Farmer, Director of Organisation Development, Western Sussex Hospitals NHS Foundation Trust