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Process and impact of mergers of NHS trusts: multicentre case study and management cost analysis

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Abstract

Objective To study the processes involved in and impact of mergers between NHS trusts, including the effect on management costs.

Design Cross sectional study involving in depth interviews and documentary analysis; case study to compare savings in management costs between case trusts and control trusts.

Setting Nine trusts (cross sectional study) and four trusts (case study) in London.

Participants 96 interviews with trust board members, other senior managers, clinicians, service managers, and representatives of health authorities, regional office, community health councils, local authorities, other trusts in the area, and primary care groups and trusts.

Main outcome measures Stated and unstated drivers, and impact of merger on delivery and development of services, management structures, and staff recruitment, retention, and morale. Effects of difference in trust size before and after the merger. Savings in management costs two years after merger.

Results Some important drivers for merger are not publicly stated. Mergers had a negative effect on delivery of services because of a loss of managerial focus on services. Planned developments in services were delayed by at least 18 months. Trusts' larger sizes after mergers had unintended negative consequences, as well as predicted advantages. The tendency for one trust's management team to dominate over the other resulted in tension. No improvement in recruitment or retention of clinical and managerial staff was reported. Perceived differences in organisational culture were an important barrier to bringing together two or more organisations. Two years after merger, merged trusts had not achieved the objective of saving £500 000 a year in management costs.

Conclusions Important unintended consequences need to be accounted for when mergers are planned. Mergers can cause considerable disruptions to services, and require greater management support than previously acknowledged. Other organisations undergoing restructuring, such as primary care groups developing into primary care trusts and health authorities merging into strategic health authorities, should take these findings into account.

Introduction

Many mergers and reconfigurations of NHS trusts have taken place in recent years. Since 1997, 99 mergers of trusts have taken place; 14 in London. These include horizontal mergers of acute hospitals, mental health trusts, and community health services trusts. More recently, primary care groups have merged to create primary care trusts.¹ Reconfigurations have often been

contentious politically—they even provided the focus in one constituency during the general election of 2001.² This led to the establishment of the independent reconfiguration panel, which aims to adjudicate on proposals about mergers and reconfigurations to “take the politics out” of such decisions.³

There is a range of different drivers for trust mergers. One aim is to achieve economic gains: firstly, by taking advantage of economies of scale and scope (especially with regard to management costs),⁴ and secondly, as a result of rationalising the provision of services by reducing excess capacity to treat patients.⁴ Some people assume that clinical quality improves as usage of specialised units increases,⁵⁻⁷ quality of medical training increases,⁸ and staff recruitment and staff retention become more effective.⁹

Political drivers for mergers include facilitating hospital or service closures, securing financial viability of smaller organisations, and (on the part of providers) ensuring increased negotiating power and a survival strategy by pooling resources and enlarging the organisation in response to challenges from purchasers of services.¹⁰ For mental health services, the belief that mental health trusts with a single focus can provide higher quality services has provided additional impetus for mergers.^{11 12}

Sceptics of mergers argue that the evidence for benefits of horizontal mergers is patchy, contradictory, and often based on managers' beliefs about the benefits.^{4 10} Unintended consequences and potential drawbacks of mergers receive less attention. These include disruption of services as a direct consequence of mergers, diseconomies of scale, and problems with staffing, service integration, systems integration, and working practices, as well as issues of equity and access to services.^{4 10 13}

We studied the processes involved in and impact of trust mergers with a cross sectional study, a management cost analysis, and a case study of four trusts.

Methods

We studied the process of merger in a cross sectional study of all nine trust mergers and reconfigurations in London which became established in April 1998 and April 1999. These involved the dissolution of 25 constituent trusts and the creation of 11 newly merged trusts. We also conducted in depth, longitudinal case studies of four of these mergers.

Cross sectional study

The cross sectional study comprised an analysis of the public consultation documents for the nine proposed trust mergers and semi structured interviews with 14 managers in seven health authorities associated with the trusts. We aimed to identify the “stated” and “unstated” (not publicly stated) objectives of each merger.

Case study

In the case study, we studied one merger involving acute care trusts, one involving mental health trusts, and two involving community NHS trusts over a two year period in the second and third years after merger.

We interviewed 22-26 people per case (96 interviews in total). A core group of informants was interviewed in every case. We asked interviewees about the drivers for merger, the processes involved in the merger, and their assessment of the merger's impact on a range of issues related to service delivery, including objectives set before the merger. For details of the informants and the analysis see bmj.com.

Savings in management costs for the four trusts in the case study were estimated by comparing the actual costs (as reported in audited annual accounts for the first two years after the merger) with an estimate of the costs if no merger had taken place. A control group of eight trusts not involved in a merger or major reconfiguration (any change in income > 20% in successive years) since 1995-6 was used to predict the costs if no merger had taken place. We used a sensitivity analysis to test the effect of different assumptions on the relation between income and management costs. The post-merger trusts used in the case study did not simply amalgamate the services of their constituent trusts—substantial increases and decreases in income associated with changes in provided services were seen. We adjusted the estimated savings in costs in 1999-2000 and 2000-1 to account for differences between actual and predicted incomes by using the different levels of variable costs produced by the sensitivity analysis.

Results

Stated and unstated drivers

Stated drivers (from public consultation documents) gave the official view of the background to and reasons for the merger, as well as the favoured organisational structure. These included a need to make internal savings in management costs and invest savings into services for patients, to safeguard specialist units and guarantee developments in services, to ensure that quality and amount of services provided were maintained in the light of external policy drivers that put additional pressures on services, and to improve conditions and career prospects for staff and solve recruitment and staff retention problems. For acute trusts, there was a need to respond to various service and policy reviews that recommend concentration of some acute and specialist services. Community trust mergers aimed to support development of primary care.

Unstated drivers were concerned with specific local issues about one or more of the constituent trusts and were as reported by key stakeholders during interviews. These included a need to impose new management regimes on trusts perceived by health authorities or regional office as “undermanaged” or “lacking control,” to negotiate reductions in accumulated deficits of one of the constituent trusts (because new organisations could not be expected to carry the burden of deficit from the start), and to respond to lobbying from stakeholders—including central government, influential institutions, and pressure groups—on behalf of one or more constituent trusts.

Impact of merger on service delivery

The detailed results from all four cases are given on bmj.com. Mergers had a negative effect on the delivery and development of services. Interviewees from inside and outside the trusts reported that the loss of managerial focus on services during the merger had some detrimental effects on patient care. Service developments were delayed by at least 18 months, and senior management had underestimated the timescale and effort involved in the mergers. Some positive effects of mergers on service developments were reported; these related, for example, to the fact that there would be more clinicians in smaller services to run them effectively.

Trust size—does it matter?

The advantages of large trust sizes were mostly stated objectives of the merger, the disadvantages were unintended consequences.

The benefits of larger organisations created by mergers include the presence of a larger pool of professional staff; this enables organisations to develop large teams of specialists, which allow clinical excellence to be achieved. Previously fragmented specialist services become unified and enhanced—for example, the child and adolescent mental health services in mental health trusts. Community trust managers thought local authorities paid more attention when trusts became larger. In the mental health trust, the increased size was thought to facilitate cross fertilisation of ideas. Increased opportunities for staff training were an immediate and tangible benefit, and professional networks were enhanced.

The drawbacks included the fact that staff felt that (senior) managers had become remote, and service managers felt cut off from the services that they were managing. Staff in the acute trust felt that senior managers did not devote enough time to them and that their needs for help from the managers were ignored. Respondents originating from smaller trusts felt a loss of the informality and familiarity of the previous organisations and a decrease in the autonomy of services and local decision making. Large trusts were seen as unresponsive and slow to make decisions. External stakeholders were concerned about the ability of large trusts to oversee continued quality of services and patient care. Agencies used to having direct access to senior management had to deal mainly with middle management—this compromised strategic developments in some areas of service. The larger geographical area covered by the merged trusts increased travelling time between sites for managers. Internal communication was negatively affected—processes of communication were viewed as incoherent and slow in merged trusts.

Management structures

Changes in the trusts' management structures created tensions within staff groups and between clinical staff and management. Although the competition for management posts followed NHS guidelines, the new senior management team tended to consist predominantly of staff from one of the constituent trusts; this created the impression of a “takeover” for many staff (see bmj.com for details). On the positive side, mergers provided individual staff and services with an opportunity to emerge from the constraints of previously stagnating services and management organisations.

Estimated savings in management costs in the study trusts in the first two years after merger, by cost assumption (% of income) used in sensitivity analysis

Variable	Savings (£000)				
First year after merger (1999-2000)					
Cost assumption (% of income)	5.15	5.00	4.85†	4.70	4.55
Mean saving in management costs (95% CI)‡	59.8 (-0104.5 to 224.1)	119.3 (-55.6 to 294.2)	178.7 (-20.3 to 337.8)	238.2 (-5.6 to 470.8)	297.5 (25.6 to 569.5)
Savings in trust:					
1	-76.7	34.5	-7.6	-49.7	-91.7
2	80.8	169.6	258.5	347.4	436.1
3	-79.7	-4.3	71.2	146.7	222.0
4	161.5	277.2	392.8	508.5	623.8
Second year after merger (2000-1)					
Cost assumption (% of income)	4.45	4.3	4.15†	4.0	3.85
Mean saving in management costs (95% CI)‡	200.4 (-129.6 to 530.4)	273.7 (-56.8 to 604.3)	346.8 (5.3 to 688.2)	420.0 (58.1 to 781.9)	493.2 (102.8 to 883.5)
Savings in trust:					
1	273.8	230.4	187.1	143.8	100.5
2	19.1	128.5	237.5	346.6	455.8
3	198.8	293.0	386.8	480.7	574.7
4	309.9	443.1	575.8	708.7	841.7

†Actual variable costs for control trusts for relevant year.

‡Compared with control trusts.

Staff recruitment, retention, and morale

Findings to date have not revealed a substantial improvement in staff recruitment or retention during the early stages of mergers, despite this being a prominent stated driver. Benefits to staff of mergers included improved systems of clinical supervision, more coherent professional management, and the advantages of programmes of appraisals, training, and career development that have been implemented. Clinical and managerial staff, however, emphasised the stress caused by the perceived imposed uncertainties and changes and the increase in workload associated with the process of merger.

Organisational culture

Respondents used the term “culture” to highlight the differences between the organisations and to explain conflicts of values and priorities. Differences in culture related to attitudes to innovation and risk taking—an outcome of process orientation—and patterns of communication.

Financial issues and management cost analysis

Interviews with finance managers indicated that the clearest source of potential savings from the merger was the £500 000-£750 000 that was associated with reduced numbers of members of management boards in the merged trusts. Finance managers were less convinced that other savings were achieved within the first financial year, and they had no clear evidence that savings were reinvested into services. Instead, they thought the mergers highlighted hidden financial problems in the constituent trusts and revealed differences in funding and staffing of services across the merged organisations.

Our cost analysis indicates that reductions in management costs after the mergers were less than the estimated target savings of £500 000 a year. On the basis of the actual variable costs in the control trusts, average management cost savings were calculated as £178 700 (95% confidence interval -£20 300 to £377 800) in the

first year after merger and £346 800 (£5300 to £688 200) in the second (see table). The savings were not consistent between the trusts in the case studies, and they were sensitive to changes in the variable cost assumptions used in the sensitivity analysis.

Discussion

The formation of large organisations through mergers had benefits and drawbacks. Benefits were mostly stated objectives of the mergers, but drawbacks arose during the process of merger and were not considered when the decision on whether to merge was made.

The amount of time needed for organisational restructuring was underestimated by the people who initiated the mergers and by those who implemented them. Such delays are important unintended consequences of mergers that must be taken into account in future plans for reorganisation.¹³

Differences in cultures between merging organisations seem to be an important barrier to bringing organisations together through a merger. Particular aspects of organisational culture cited in our study—such as attitudes to innovation and risk taking and whether an organisation has more of an outcomes or process orientation, and patterns of communication—are highlighted as keys to the future direction of health services.¹⁴

The low savings in management costs achieved, particularly in the first year after the merger, suggest that the implementation of mergers needed more management support than had been anticipated. Merged organisations thus need to set realistic objectives in terms of savings in management costs by taking into account the amount of managerial input needed to implement the merger.

Other studies in the United States and the United Kingdom showed that the results of mergers are disappointing and that it takes a long time for positive results to show.^{13 15 16} Our study may have been

performed too soon after mergers to judge whether or not they met their objectives, given the length of time taken to achieve considerable change in healthcare organisations. The results from the second stage of our data collection for the case study, which took place during the organisations' third year of operation (data are currently being analysed), may show that the merged trusts are closer to meeting the mergers' objectives. The longer the timeframe used, however, the more difficult it is to attribute effects—for example, the impact on service developments—to the merger process, given the context of a turbulent environment of change within the NHS.

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What is already known on this topic

Research suggests that effectiveness increases as the amount of activity by specialised units in certain clinical specialities increases

Little empirical research has looked at the impact of mergers; most studies focus on financial variables

Mergers result in short term disruption caused by difficulties in integrating services and personnel

What this study adds

Important drivers for NHS mergers that are not stated publicly have implications for the process and impact of mergers

Mergers have positive effects, as well as unintended negative consequences that disrupt services and set back developments in services

Perceived differences in organisational culture impede bringing organisations together

Mergers do not achieve target savings in management costs in first two years after merger

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Association between competing interests and authors' conclusions: epidemiological study of randomised clinical trials published in the *BMJ*

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Abstract

Objective To assess the association between competing interests and authors' conclusions in randomised clinical trials.

Design Epidemiological study of randomised clinical trials published in the *BMJ* from January 1997 to June 2001. Financial competing interests were defined as funding by for profit organisations and other competing interests as personal, academic, or political.

Studies 159 trials from 12 medical specialties.

Main outcome measures Authors' conclusions defined as interpretation of extent to which overall results favoured experimental intervention. Conclusions appraised on 6 point scale; higher scores favour experimental intervention.

Results Authors' conclusions were significantly more positive towards the experimental intervention in trials funded by for profit organisations alone compared with trials without competing interests (mean difference 0.48 (SE 0.13), $P=0.014$), trials funded by both for profit and non-profit organisations (0.30 (SE 0.10), $P=0.003$), and trials with other competing interests (0.45 (SE 0.13), $P=0.006$). Other competing interests and funding from both for profit and non-profit organisations were not significantly associated with authors' conclusions. The association between financial competing interests and authors' conclusions was not explained by methodological quality, statistical power, type of experimental intervention (pharmacological or non-pharmacological), type of control intervention



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