

Making mergers work

Improvements NHS providers have achieved through merger

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About NHS Improvement

NHS Improvement is responsible for overseeing foundation trusts, NHS trusts and independent providers. We offer the support these providers need to give patients consistently safe, high quality, compassionate care within local health systems that are financially sustainable. By holding providers to account and, where necessary, intervening, we help the NHS to meet its short-term challenges and secure its future.

NHS Improvement is the operational name for the organisation that brings together Monitor, NHS Trust Development Authority, Patient Safety, the National Reporting and Learning System, the Advancing Change team and the Intensive Support Teams.

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Introduction

This paper is for executive teams of NHS providers who are considering, planning or implementing a merger,¹ and forms part of a series prepared by NHS Improvement.² It sets out the improvements that NHS providers have achieved through merger and how a merger contributed to their delivery. This will help executive teams identify what types and size of improvements are possible, the likely timescale required to deliver them, and the extent to which a merger might be necessary to deliver them.

Mergers have the potential to lead to higher quality and more cost-effective care. Figure 1 below provides an overview of the types of improvements that have been achieved by some NHS providers in past mergers, based on our literature review and interviews with six NHS providers.³ The sections below provide an overview of the extent to which and how these improvements have been delivered and their scale.

Figure 1 Improvements that can be achieved through a merger

Improvement	
Improvement in clinical service delivery	<ul style="list-style-type: none"> • Relocating, consolidating and introducing new services • Implementing best practice clinical processes and models • Standardising clinical practice and processes • Improving and rationalising estate • Improving clinical research (eg easier to recruit top academics and for trials)
Corporate overhead savings	<ul style="list-style-type: none"> • Consolidating hospital boards and senior management • Integrating back-office functions (eg finance, HR, IT, legal and estate management)
Clinical savings	<ul style="list-style-type: none"> • Integrating clinical support services and management • Centralising the procurement function
Workforce improvements	<ul style="list-style-type: none"> • Aligning roles and pay grades • Increased ability to recruit and retain clinical and non-clinical staff

¹ In these documents, we use the term mergers to refer to both mergers and acquisitions.

² Two additional papers have been published alongside this paper: [Factors affecting the success of NHS mergers](#) describes key factors that can affect the delivery of service improvements and savings through merger. Looking at the merger process from beginning to end, [Mergers in the NHS: lessons learnt and recommendations](#) sets out the biggest challenges that people leading merging trusts should anticipate and gives practical advice on how to overcome them.

³ The findings from these interviews are reported in more detail in: Aldwych Partners. [Benefits from mergers: lessons from recent NHS transactions](#).

Improving clinical service delivery through a merger

Mergers are often used to improve patient experience and clinical outcomes through transforming how services are delivered. At least half of the interviewed providers cited this as a reason for their merger. Their plans included making extensive service delivery changes through relocating, consolidating or introducing new services.⁴

Improving how services are delivered can create significant financial savings. For example, McKinsey & Company estimates that service consolidation can contribute in some cases to operating cost savings of between 12% and 14% (compared to between 1% and 2.5% without service consolidation) through standardising and integrating work processes, support functions, suppliers and investments.⁵

However, changing how services are delivered can be the most difficult type of improvement for providers to make. Factors that can stand in the way of improving how services are delivered include a lack of a clear and sustained vision for how and why services should be transformed; a lack of support for proposed changes from clinical leadership or other stakeholders; and a loss of momentum when implementing the changes. We discuss these factors in more detail in *Factors affecting the success of NHS mergers*.

In spite of these challenges, there are cases of successful transformation of services through a merger (see Examples 1 and 2). Interviewed providers who achieved such improvements said they took longer to achieve than other types of improvements (eg at least two to three years compared to 12 months to deliver corporate overhead savings). The need to ensure internal and/or external stakeholder support before implementation and the complexity of implementing service delivery changes were seen as major reasons for the longer length of time needed.⁶

A merger can be an important facilitator of service change, even when not strictly required to deliver it.⁷ Providers said that a merger can provide the impetus for the clinical and managerial action necessary to initiate the change. One said decision-making was quicker as a result of the single management structure created by the merger. However, a merger can also distract senior management from delivering

⁴ Aldwych Partners. *Benefits from mergers: lessons from recent NHS transactions*, paragraph 72.

⁵ McKinsey & Company (2012) *Marry in haste, repent at leisure: when do hospital mergers make strategic sense?* p. 7
www.mckinsey.com/~media/McKinsey%20Offices/United%20Kingdom/PDFs/When_hospital_mergers_make_strategic_sense_ashx

⁶ Aldwych Partners *Benefits from mergers: lessons from recent NHS transactions*, paragraph 7.

⁷ Aldwych Partners. *Benefits from mergers: lessons from recent NHS transactions*, paragraphs 126 to 135.

service change or make it easier to defer difficult changes. Poorly configured or inefficient services may as a result be more likely to survive in a larger organisation.⁸

Example 1: Reorganising services across sites to improve patient outcomes

One provider acquired a hospital where the emergency services were being used by very low numbers of patients and which had a relatively high hospital standardised mortality ratio (HSMR) score. Following the merger, the acquired hospital's A&E department was transformed into an urgent care centre supported by a high-dependency unit. A separate elective orthopaedic centre was also developed at that site, and several services were transferred from the acquiring provider's main hospital site, including planned elective orthopaedics, some surgical day case activity and outpatient services. The acute services required to support an A&E department were then relocated to the acquiring provider's hospital that delivered emergency services. As a result of these changes, one commissioner said that the acquired hospital now has a lower HSMR score and they considered it a better clinical site.

Executives explained that significant work was required to change public perception of the acquired hospital from one of a poorly performing acute hospital to one of a high-performing elective surgery and rehabilitation centre. The process from merger to service change took approximately 18 months. This included deciding how to reorganise services, consulting with clinical staff, and the commissioners' public consultation process.

Example 2: Standardising clinical processes to improve patient outcomes

One provider achieved improvements by standardising clinical processes across two formerly separate providers as follows:

1. Where one provider was delivering better outcomes than the other through a different care pathway, the merged provider adopted this pathway across the merged organisation.
2. Where neither site was delivering outcomes in the top quartile of NHS performance for that service, the merged provider reviewed national best practice and used this to design the delivery of better patient care.
3. The merged provider reviewed any service that had received performance warnings, such as rises in the mortality indicator, to identify and improve the care pathway.

⁸ NHS Improvement, *Literature review: the experiences of healthcare providers in delivering merger objectives*, p.8.

The merged provider standardised processes for services including those for fractured neck of femur, hip and knee replacement, stroke and maternity. It said that the standardisation of these processes improved patient care, reduced length of stay and has been a big contributor to reducing mortality levels at the hospital.

Delivering financial savings through a merger

All the interviewed providers reported financial savings from consolidating corporate and clinical support functions of between 1% and 3% of turnover. Most said that these savings can be achieved within six to 12 months of the merger. The speed with which savings are realised depends on the level of detail to which the merging providers plan their organisational structure, though even those who decided this structure post-merger saw savings within 12 months.

Corporate overhead savings through a merger

Corporate overhead savings can be achieved by adopting a unified management structure with a single board, chief executive and senior management, and consolidating back-office functions such as finance, HR, IT, legal and estate management. The literature suggests that 0.5% to 1% of turnover can be saved by consolidating board and senior management.⁹

However, not all corporate overhead savings require a merger. While a merger might naturally lead to the consolidation of the providers' boards and senior management, back-office functions can be integrated across two or more providers without merging the rest of their organisations (see Example 3).

Example 3: Achieving synergies in information management and technology without a merger

In the years preceding their merger, two providers were part of a strategy developed by the local strategic health authority (SHA) to improve the co-ordination of care across the region and increase the clinical links between them. Individual patients often used services from both providers. This meant that better co-ordination of information management and technology (IM&T) was a priority as patient records needed to be shared efficiently between the two providers.

One integrated IM&T system was established to serve both providers. A jointly funded director of IM&T was appointed to sit on the boards of both organisations. This streamlining was successfully achieved without the need for a merger at organisational level.

⁹ NHS Improvement, *Literature review: the experiences of healthcare providers in delivering merger objectives*, p.5.

Clinical savings through a merger

Providers said that savings can be made by consolidating the management of clinical services and other support roles, such as the procurement of clinical equipment and products, infection control, clinical governance, pathology (see Example 4) and pharmacy. Some said that these clinical savings can be more difficult to achieve than corporate overhead savings. The savings from unifying the management of clinical services may also be comparatively limited:

- Several providers said they needed to maintain site-based management structures alongside organisation-wide service-level structures.¹⁰ The challenges of maintaining effective clinical leadership increase with the number of sites and the distance between them, and it is important that any travel requirements do not prevent timely day-to-day management operations and also allow managers to maintain strong working relationships with operations staff.¹¹
- Providers said that the demands on clinical service managers may only become apparent over time, and the clinical management structure may require some adjustment in future.¹² For example, two providers said that, having initially adopted one management structure across all sites (which can help create a single culture), site-based operational management was later implemented following a review.¹³

Most providers said centralising the procurement of clinical equipment and products can take time to generate savings, as agreement and support to change supplier or product often first needs to be gained from clinicians (see Example 5).

It should be noted that realising some of these savings does not require a merger. In particular, consolidating clinical support services (eg pathology services) and centralising procurement functions can be achieved through other arrangements.

Example 4: Realising savings in clinical support services

One provider successfully transformed its pathology services. Non-urgent pathology services were centralised at its main hospital, while urgent and other essential services were maintained at all its sites. A higher degree of automation was introduced at the main site, which reduced the cost of processing tests. Centralising core pathology services at the main site also used previously spare capacity.

¹⁰ Site-based managers make day-to-day decisions about various critical site-based issues, such as bed management and staff rosters.

¹¹ Aldwych Partners. *Benefits from mergers: lessons from recent NHS transactions*, paragraphs 167 and 168.

¹² See footnote 11, paragraph 47.

¹³ See footnote 11, paragraphs 46 to 48.

Another provider introduced an internal recharging system for cost accounting to help individual departments understand the relative costs of clinical support services, such as radiology and pathology.

Example 5: Realising savings by centralising the procurement function

One provider delivered procurement savings by negotiating better prices with suppliers, particularly where the merging organisations had been paying different prices for the same product, and by consolidating suppliers or products for clinical procedures. Procurement savings were primarily achieved in clinical services requiring high-cost inputs, such as orthopaedics. Another provider achieved procurement savings through similar methods for pressure-relieving aids and equipment (£100,000 per annum) and also printer cartridges (£125,000 per annum).

Two interviewed providers noted that procurement could be a difficult area in which to deliver savings and that these had been slower than planned due to the need to obtain clinician agreement to use a single supplier for various clinical products. One interviewed provider explained that clinicians might prefer a certain (and different) supplier for particular products because they become accustomed over time to performing a procedure in a specific way. Different products may require a clinician to re-train before using them, and may have different clinical advantages and disadvantages. These differences need to be assessed by the wider clinical team before deciding to change products.

One provider implemented a new IT system that records patient costing and allows comparison of cost margins for providing services across departments. The system gives clinicians a way to compare their performances and identify opportunities for savings.

Workforce improvements through a merger

Workforce savings can be achieved by aligning roles and pay grades across previously separate providers, and by reducing expenditure on temporary staff if the merger makes it easier to recruit permanent staff.

A number of providers said that becoming a single larger organisation helped them recruit and retain staff due to the greater opportunities available to staff working at a larger organisation (see Example 6). This can lead to temporary (ie bank and agency) staff being replaced by permanent staff. However, providers said that

aligning roles and pay grades after the merger can be challenging and difficult to complete quickly (see Example 7).¹⁴

Example 6: Easier recruitment and better retention of staff

One provider said that before the merger it had found it difficult to recruit staff for the A&E department at one of its sites. The merger allowed the provider to fill its A&E rotas entirely with permanent staff. This meant an increase from two whole-time equivalent (WTE) consultants to a full team of eight within 18 months of the merger. Executives said easier recruitment is likely to have been due to the attractiveness of working as part of a larger team across the merged organisation, including opportunities to work at the major trauma centre at another site.

Example 7: Aligning roles and pay grades

One provider found that the smaller provider it acquired had been attracting and retaining staff by categorising staff roles at higher-than-average pay grades. Unlike larger providers they could not attract staff by offering better career opportunities and progression or education programmes. As part of the merger, salary grades for the same roles were aligned across the merged organisation, resulting in cost savings.

¹⁴ Aldwych Partners. *Benefits from mergers: lessons from recent NHS transactions*, paragraph 51.



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NHS Improvement is the operational name for the organisation that brings together Monitor, NHS Trust Development Authority, Patient Safety, the National Reporting and Learning System, the Advancing Change team and the Intensive Support Teams.

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