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All Pain and No Gain? A Study of Mergers of NHS Trusts in London: Two-Year Post-Merger Findings on the Drivers of Mergers and the Processes of Merging

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Mergers have been a prominent feature in the health care agenda of both the USA and the UK in the last 30 years. In the British NHS, the number of trust mergers and reconfigurations has dramatically increased over the last 10 years (99 trust mergers between 1997–2001), and these have generally been horizontal mergers of acute, mental health and community Trusts.

The literature on health care mergers identifies a number of drivers for Trust mergers, such as economic gains; improvements in clinical quality; the ability to recruit and retain staff more effectively; facilitating hospital or service closures; and securing the financial viability of smaller institutions (McClenahan *et al.*, 1999). Although numerous benefits are expected to arise from these organizational changes, studies of mergers in the corporate and health care sector show that these benefits rarely materialize, and even in the few cases where they do, it is argued that organizations can take up to two years to recover from the unintended consequences and drawbacks of the merging process (*ibid.*).

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Ashenkas *et al.* (1998, p. 166) argue that despite the potential benefits of mergers, few organizations go through this process often enough to develop a pattern, simply because the process itself is often a 'painful and anxiety-producing experience...[involving] job losses, restructured responsibilities, derailed careers, diminished power and much else that is stressful'. Regardless of this, mergers in the NHS have become a repeated process (Gould, 2000).

The findings discussed in this chapter, two years post-merger, suggest that although certain gains can be achieved from full organizational merger, this is not achieved without a number of drawbacks and unintentioned negative consequences that are often overlooked or underestimated by both policy-makers and managers in the early strategic planning stages of a merger.

Background

There are two main types of mergers. *Vertical mergers* involve the combination of firms at different stages of the production process, with a single firm producing the goods or services that either suppliers or customers could provide. *Horizontal mergers* involve the combination of two or more firms producing similar goods or services (Ferguson and Goddard, 1997).

In the corporate sector and in private-sector health care, such as in the USA, merger activity is mostly driven by price competition, the desire to consolidate operations in order to remain viable, to acquire market power, and to take advantage of a monopoly situation (Alexander *et al.*, 1996). Sinay (1998) adds that in the USA, hospital merger activity initially increased with the expansion of managed care plans and the implementation of Medicare's Prospective Payment System, which changed reimbursement procedures from cost-based to case-based. In publicly-funded health care systems, however, such as in the UK where NHS Trusts do not have a strong profit-making incentive, mergers are products of a number of drivers. Meara and Millard (1998) identify eight such factors (see Table 13.1).

The majority of the literature on hospital mergers, most of which concerns the US experience, focuses on efficiency gains and savings through economies of scale as the primary drivers for merger. Some of the earlier reports from the NHS suggest that mergers were introduced to deal with the spare capacity available in the acute sector, thus creating short-run cash savings and reducing average costs by better utilizing resources and avoiding duplication (Ferguson and Goddard, 1997).

Table 13.1 Factors which might render a trust vulnerable to merger

Vulnerability factors	*Comments*
Size of Trust turnover limited to management cost reduction targets	For example under £20m
Lack of coterminosity with partner services	Especially relevant to community Trusts
Failure to meet financial targets	If persistent
High management cost–turnover ratio	Could be triggered by purchasers transferring elements of service elsewhere
Lack of critical mass to sustain specialist services	Especially with reference to clinical staff recruitment
Perception of poor management	Could relate to failure to develop effective services
Recognized need for service rationalization	Merger seen as a precursor
Local political factors	For example desire for coterminosity

Source: Meara and Millard (1998).

It has been argued that hospital mergers can produce some savings through improved patient volumes, operational changes, and consolidation of support and administrative services (Bojke and Gravelle, 2001; Greene, 1990; Lynk, 1995). In terms of efficiency and effectiveness indicators, a US study of 32 mergers of non-profit hospitals by Treat (1976) found that merged hospitals produced a wider range of services than non-merged hospitals. However, a review of the literature on economies of scale and scope by Aletras *et al.* (1997) found that although merging could reduce costs through management cost savings, if the size of hospitals increases past a certain size (over 300 beds) it can lead to diseconomies of scale, from increased average costs and additional sources of costs. Aletras *et al.* (1997) conclude that the evidence on whether hospital mergers generate cost savings through the exploitation of economies of scale is inconclusive and that no evidence exists to suggest that mergers reduce costs overall.

Moreover, evidence from the USA and the UK suggests that many of the expected benefits of mergers, particularly cost savings, rarely materialize post-merger and that positive effects take a long time to present themselves (McClenahan, 1999/2000; Treat, 1976; Ferguson and Goddard, 1997). For example, in the UK, cost savings from reducing management costs are estimated at £200,000–£300,000 per year, which

McClenahan (1999) suggests is less than 1 per cent of the total budgets of the merged organizations. In terms of evidence from sectors other than health care, reviews of literature from the USA and the UK suggest that in many cases efficiency declines post-merger due to unforeseen problems in integrating the merging firms (Haspeslagh and Jemison, 1992; Buono and Bowditch, 1989).

Government policy on appropriate models of service delivery has played a key role in the introduction of mergers in the UK. The 'Calman–Hine Report' (1995) highlighted the need for the creation of cancer units and centres, requiring trusts to form alliances and pull together resources. In addition, changes in medical staff training have in turn caused pressure for the concentration of services. The Calman reforms to specialist medical training, for example, may threaten the accreditation of small hospitals and departments unless they integrate into larger units (Ferguson and Goddard, 1997).

Mergers have also been introduced in order to improve clinical quality of services provided through higher concentration of specialist services. A review of the research on the volume–outcome relationship of clinical services conducted by Sowden *et al.* (1997) found that although for some procedures and specialties, quality gains can be achieved as volume increases, most research studies overestimate the level of impact of volume on quality of care.

A number of US studies (Bogue *et al.*, 1995; Weil, 2000) have found that mergers are often proposed to facilitate hospital or service closures. For a 'failing' hospital with an uncertain future, where there is excess capacity due to falling demand of specific services, a merger is often regarded the more attractive alternative to closure, since it is hoped that the hospital will continue to provide some, if not all, services post-merger.

Studies have shown that the merging process has been found to have adverse effects on hospital staff. Greene (1990) studied the merger of 36 US hospitals, concluding that despite some operational improvements, most of the merging hospital staff experienced increased stress from fear of job loss and a loss of morale and productivity for several years. McClenahan *et al.* (1999) argue that *all* mergers have negative short-term effects on staff, and may easily become a physical and/or mental health-threatening event as concerns for personal job security, changing work practices (and often environment) and apprehension about loss of autonomy, nurture fears of organizational change. It seems that mergers do not only affect remaining staff who might be disillusioned. Shaw (2001) and Allen and Sharar (2000) suggest that clinical staff and senior managers experience a 'post-merger stress syndrome', characterized by

fiscal pressures, workload, feelings of lack of appreciation or reward, anger/stress, and loss/grieving.

Organizational culture is a significant yet often neglected factor in the merger process, which is an important aspect in explaining differences in work practices and approaches in the merged organizations. Handy (1993, p. 181) defines culture as an organization's 'deep-set beliefs about the way work should be organized, the way authority should be exercised, people rewarded, and people controlled'. Garside and Rice (1994) point to studies in the USA that show that a significant percentage of hospital mergers fail when issues surrounding organizational culture are ignored. The likelihood of failure is said to increase as the gap between the merging hospitals' cultures widens, which can often lead to low staff morale and productivity, job dissatisfaction, absenteeism and high staff turnover.

Mergers have also been reported to consume large amounts of time and effort from senior management; management is often unrealistic and overconfident about the time requirements and the difficulties involved in a merger (McClenahan *et al.*, 1999; Garside and Rice, 1994). Indeed, Hackett (1996) argues that ineffective management of the merger process leads to discord and disharmony, and is one of the main reasons why mergers fail.

The study reported in this chapter aims to address these issues by analysing the *process* and *impact* of mergers.

Research methodology

Aims

This study aims to increase the understanding of organizational restructuring and change in health services by focusing on the impact of the merger process on the management, organization and delivery of services, and on management costs. The study includes a management cost analysis of the financial data of merged and non-merged Trusts in London Region for 1999/2000 and 2001/2002, using regression analysis. The findings of the management cost analysis are reported elsewhere (see Fulop *et al.*, 2002; Hutchings *et al.*, 2003) We present findings of two phases of the project:

1 a cross-sectional study of all nine merged Trusts in the London area which came into existence between 1998 and 1999; and
2 the first phase of work in four case study sites, two years post-merger.

Data collection

The aim of data collection is to follow up the multifaceted processes of mergers over time and to contextualise the case studies within other mergers and reconfigurations in the London Region (see Table 13.5 in the Appendix).

The cross-sectional study

Consultation documents of all proposed reorganizations to Trusts in London Region since 1998 were collected. Nine management mergers were included in the study (Table 13.2), and 14 representatives in seven Health Authorities (HAs) involved in the mergers were interviewed.

Case studies

Our four case studies consisted of mergers in one acute, one mental health and two community NHS Trusts, all of which came into effect in 1999. Case study Trusts were selected 'purposively' (Bowling, 1997) to ensure the range of Trust types and geographical spread in London (two north, two south). The purpose of the case studies was to explore in greater depth the process of merger, assess how far the objectives of each merger had been met, and their intended and unintended consequences. In all, 22–6 interviews were conducted in each case study with a range of stakeholders, both internal and external to the trust (see Table 13.3).

Analysis of cross-sectional and case-study data

Data from the cross-sectional study and the case studies were analysed using 'contextualism', which combines the study of different perspectives and temporal and historical contexts in the analysis of organizational change and process, extracting theory from the ground up (Pettigrew, 1985).

Table 13.2 Mergers included in the cross-sectional study

Trust type	*Number of mergers/ reconfigurations*	*Number of resulting merged trusts*
Acute	5	5
Community	2	2
Mental health	1	3
Mixture of above	1	1

Table 13.3 Number of interviews in each case study site

Case study Trusts	*Interviews with senior trust managers (chief executive, medical director, HR director, etc.)*	*Interviews with service managers (management and professional)*	*Interviews with external stakeholders (CHC, PCG/T, LA)*	*Total*
Acute Trust	8	10	7	25
Mental Health Trust	9	9	5	23
Community Trust I	9	6	11	26
Community Trust II	6	6	10	22
Total	32	31	33	96

In the cross-sectional study, the analysis of the consultation documents and the interviews with HA representatives focused on the background, drivers and objectives of the mergers. The analysis drew out common reasons for the proposed mergers and highlighted noteworthy differences. The data are presented in an anonymized form so that Trusts and respondents cannot be identified.

Findings

Drivers for merger

The stated drivers for merger extracted from the merger consultation documents gave the official view of the background to and the reasons for the mergers and the favoured organizational structures. The 'unstated' drivers reported by key stakeholders internal and external to the Trusts, during the case-study interviews, concerned specific local issues with one or more of the constituent Trusts.

Stated drivers

These were obtained from an analysis of public consultation documents and confirmed by interviews with HA representatives. The need to make savings featured as a significant driver in all the consultation documents, but key stakeholders did not agree about their importance. Interviewees, however, agreed that financial pressures were a significant driver for the mergers. These included budget reductions in the

HA, either because of previous overspends or because of anticipated reductions in HA budgets in the future. Trusts' budgetary deficits were one of the central drivers for acute and community mergers, and both types of mergers sought to redress financial shortfalls in the predecessor Trusts.

Mergers were also seen as an opportunity for safeguarding specialist units and guaranteeing service developments. The specialist forensic unit attached to mental health Trust 23, for example, was expected to guarantee its survival within a larger mental health organization. (see Table 13.4 (p. 229) for the nomenclature used in referring to the different Trusts.)

Common to all Trust mergers was the need to ensure that the quality and level of service provision could be maintained in light of a number of external policy drivers, which put additional pressures on services; for example, the Turnberg Report (Department of Health, 1997). In the community and mental health Trusts, the reconfigurations were informed by pressures for local improvements to service delivery and for closer cooperation with local authority (LA) and partnership agencies. In particular, the national shift in policy towards community mental health services was seen as requiring closer collaboration with partner agencies in the local area.

In the original merger consultation documents, one of the drivers for community Trusts was the need to support primary-care development. The mergers were seen as securing organizational survival of community Trusts, but also as a way of maintaining a strategic role in future primary and community health developments. As larger organizations, all newly merged Trusts aimed to improve conditions and career prospects for staff. For the acute and mental health Trusts, staffing issues were cited as particularly important in informing the merger decisions. The need to bring together clinical and professional staff to form a larger staff and expertise base was also regarded by HA representatives as a central driver for all the mergers in our study. HA respondents argued that this 'critical mass' would help achieve the maintenance and development of services through the accumulation of a larger consultant base and clinical teams.

By merging, the newly established Trusts expected to be able to address staffing problems experienced in recent years. As larger and specialized organizations, the merged Trusts intended to improve the career and training opportunities for their staff, attracting suitably qualified staff and addressing some of the problems in the quality of the service suffered through sustained high vacancy levels.

Un-stated drivers

These were obtained through interviews with HA representatives and were drivers which were not publicly stated. Un-stated drivers often had a particular bearing on the type of reconfiguration adopted in specific cases or in addressing a specific local problem. Certain mergers were a way of imposing a new management regime on a Trust, which was seen by HAs or the Regional Office (RO) as undermanaged or 'lacking control'. By merging the Trusts, better management approaches could be introduced. For example, Trust 17 was seen as having underperforming community services, an issue that raised concern about the prospect for quality of services in the area.

There is evidence among a small number of the Trust mergers that there was an expectation that some of the financial deficits accumulated by constituent Trusts could be written off. None of the official documents explicitly stated this, but some HA representatives made reference to the fact that deficits had been part of the merger negotiations. In the merger of community Trust II, one of the constituent Trust had a considerable deficit. When the extent of this deficit became apparent after the merger, the new Trust negotiated for the deficit to be written off.

For a small number of Trusts, lobbying and pressure from central government, influential institutions and individuals, and from public pressure groups on behalf of one or more of the constituent Trusts played a role in driving the merger process. The merger of acute Trusts A and B was politically sensitive due to a long and high-profiled public campaign to avoid the closure of constituent Trust 4.

The following sections are based on the analysis of the case-study data in the second year post-merger.

Impact on service delivery

There was a general agreement in all the case studies that the mergers had affected service delivery. While the assessment of the merger by the senior management teams tended to focus on the more positive outcomes, both service managers and external interviewees were more critical. Negative effects were seen as the result of the temporary absence of 'management' and 'service focus' during the transition period. Several respondents reported a setback to service development of more than 18 months. However, respondents also stated that service improvements were beginning to show.

The more outlying community Trust services were particularly affected by the mergers and remained undermanaged for a period of months, unable to participate in local service development discussions. In community Trust II, for example, these delays held up the development of intermediate care services. The acute Trust merger experienced similar delays. Proposed changes to services in pathology, A&E and maternity are still not implemented, the services still operate quite independently from each other and delays are ongoing. A number of respondents, both within and outside the trusts, felt that this loss of focus had had some detrimental effects on patient care. Some Community Health Council (CHC) representatives believed that certain services had operated outside their statutory framework and neglected standards of clinical governance. They also pointed to periods of 'mounting complaints' and, in the case of the acute hospital merger, an increase in waiting times, which they felt was at least partly related to the merger.

In relation to the borough-based services, service delivery in the mental health Trust merger seemed to be least affected compared to the other case studies, largely because the devolution of service management to borough-based management was completed before the Trust merger. The mental health service seems to have had less success in integrating in-patient services – respondents reported an ingrained reluctance to share beds across the patch.

On the positive side, the merger allowed the mental health Trust and the two community Trusts to benefit from the sharing of clinical practice. In addition, the mergers united previously fragmented specialist services, raising their profile and enabling them to develop a stronger voice, and gain greater influence and more bargaining power. This was clearly evident in the forensic, substance misuse and Child and Adolescent Mental Health (CAMHS) services of the mental health Trust. Service managers in community Trust II regarded the changes introduced as the result of the Trust merger as freeing them from a stifling, old-fashioned and stagnating culture. The merged organizations allowed individuals to articulate and participate in a new vision of service delivery. The internal consultation on service models and the exchange of ideas was extensive, and service managers regarded the process as highly beneficial.

The impact of the merger process on staff

A number of common issues regarding the effects of the mergers on clinical and professional staff were identified in our case studies. Most importantly, our findings to date have not revealed a substantial

improvement in either recruitment or retention of staff. The recruitment and retention situation did not change significantly during the early stages of the mergers, and problems varied across the four case studies. Whereas some Trusts had general recruitment and retention problems (acute Trust), others had vacancies and/or difficulties recruiting in particular services only (elderly services, learning disability, and speech and language therapy in community Trust II).

Individual staff responded in different ways to the merger. Many interviewees reported the stress they experienced related to the perceived imposed uncertainties and changes, and an increase in workload. Alongside these mainly negative responses, certain interviewees reported beneficial reactions, for example in the increased autonomy in their roles, and in being given a voice in the plans for innovation and change. The pre-merger consultation processes and the months leading up to the mergers were laced with anxieties and fears for individual staff. Many staff felt anxious about having to work alongside staff groups from another organization, which they previously considered 'rivals' (acute Trust, mental health Trust, community Trust I), and a number of people decided to look for alternative employment.

The appointment process of managers was difficult for all staff. The parts of the organization that gained new management mourned the loss of their previous managers and found it difficult to relate to the new managers, especially if they originated from the rival organization.

Organizational culture

Respondents used the term 'culture' to identify perceived deep-rooted differences between constituent Trusts, and to explain conflicts of values and priorities in the Trusts. Cultural differences were particularly relevant in explaining continuing problems and delays in forming a coherent organizational identity, and culture-related issues came into relief mainly as the result of comparing differences between constituent Trusts of the merger and between the 'before and after' phases of the merger.

Cultural differences became more apparent as the merger process developed, and were most prominent in the acute Trust merger. Some respondents regarded the differences in size of the two Trusts, different philosophies and distinct problems at their respective sites as part of an unmanageable barrier between the two previous organizations:

> There might be four miles difference between us but there is two decades in terms of culture and practice. (Executive board member, acute Trust)

Cultural differences were also used to explain delay and resistance to changes in service delivery as the result of the mergers. An example of this is the failed attempt of implementing protocol-driven clinical practice in the acute Trust merger. The clinical culture in Trust 11 was based on good links between management and clinicians, good multidisciplinary links, flexible ways of working, and commitment to modernization, and so on. As a result of this wider culture, Trust 11 had been able to implement protocols widely across the hospital. At Trust 10, the clinical culture was traditional, hierarchical, medically-led and slow to change. Introducing the protocol-driven clinical practice has been much more difficult and resistance to it remains high, as the example of the failure to implement a triage system shows.

Expectations of management cost savings and their reinvestment into patient services

The merged Trusts' finance managers believed that the clearest savings achieved were the £500,000–£750,000 associated with the reduction of management boards. Our analysis, however, showed that two years post-merger, these savings had not been made. Average management cost savings were estimated at £179,000 in the first year, and £347,000 by the second year following merger (Fulop *et al.*, 2002; Hutchings *et al.*, 2003). Moreover, there was less evidence that other savings, as the result of other rationalizations for example, had been achieved within the first financial year. There was also no evidence that any savings had been reinvested into services. Instead, the mergers highlighted additional financial problems in the Trusts and identified significant differences in the funding, staffing and resourcing of services. There were concerns about the equity of budgets for services across the merged organizations.

Opinions on the potential for other cost savings and greater financial control as the result of the mergers were also divided. A number of respondents claimed that overall savings had been nominal in their Trust. In the acute Trust merger, both the HA representatives and the Trust's staff believed that management cost savings had minimal effect on the overall financial situation of the Trust. A deficit remained (£2 million overspent in the first quarter of 2000), and the view was that the merger could only achieve its financial targets in the long term.

There was doubt that any tangible benefits had come from savings. In most cases, the Trusts were not necessarily the beneficiaries of the savings made from the mergers. According to one HA representative, whatever management cost savings were made in the mental health

merger were shared out between the HAs according to fixed costs and pro-rata contributions of HAs to the Trusts, instead of reinvesting in services and facilities. In all Trusts, there was also a recognition that the merger process itself constituted a considerable financial burden and that this had been underestimated in the planning of the merger. Although management cost savings were made, external consultants were often brought to support the merging process.

Discussion

Despite the various expected gains that can be made from a merger, a number of common factors and patterns of the merger process were identified in this study, which negatively affected the management and organization of work, service provision and staff. These are the unintended consequences or drawbacks of mergers. However, it is too early to be able to assess accurately whether the merged Trusts have achieved the objectives which they set for themselves. The findings reported in this chapter are from the first stage of our study, two years post-merger. Data gathered in stage two of our case studies will reveal how the issues discussed above have played out in the third year following merger.

It is clear that the Trusts' service delivery has been affected by the mergers. The Trusts incurred delays in service development mainly as a result of the knock-on effects of delays in middle management appointments which led to setbacks in the development of the new organization and in service development of at least 18 months. Our findings confirm the results of a number of studies (Weil, 2000; Bogue *et al.*, 1995) indicating that mergers often secure the survival of smaller, inefficient hospitals.

As predicted by most studies of mergers (McClenahan, 1999/2000; Aletras *et al.*, 1997; Treat, 1976; Ferguson and Goddard, 1997), the case-study Trusts did not meet the clearly stated objective of reducing management costs by £500,000–£750,000, despite the fact that senior managers believed that these savings were made by the reduction of management boards. The lower savings achieved, particularly in the first year following merger, suggests that the implementation of mergers required more management support than had been anticipated. There was also less evidence that other savings, as the result of other rationalizations, had been achieved by the first financial year. Lastly, there was no clear evidence to indicate that savings have been reinvested into services, as it was pledged in the consultation stages of the mergers.

A prominent negative impact on staff at all levels was detected in this study – an issue that has been noted by most studies on mergers (Greene, 1990; Shaw, 2001; McClenahan *et al.*, 1999; Hancock, 1997). The merging process elicited feelings of frustration, anxiety, insecurity and fear of the unknown from staff and management at all levels, indicating that the merger process deeply affected people's work and personal lives. Consequently, many decided to look for alternate employment rather because they had no confidence in the proposed organization. Others felt anxious about having to work alongside staff groups from another organization, which they previously considered 'rivals'. Furthermore, Trust managers shared the belief that merging would improve the recruitment and retention of staff through the creation of larger, more prominent Trusts that would ultimately be seen as better employers. As such, the Trusts would be in a better position to provide staff with better opportunities, staff training and career progression. Our findings to date have revealed that there has been no substantial improvement in the recruitment or retention of staff, although in two case studies (community Trust I and mental health Trust) the merger led to improvements in training, appraisal and career development schemes.

Overall, it is evident from both our study and previous research on this topic (Hackett, 1996; Kent, 1997; McClenahan *et al.*, 1999) that the management teams involved in mergers significantly underestimated the amount of time and effort necessary for such major organizational change. The mergers examined involved bringing together two or more different organizations across geographical distances, with different policies (clinical and non-clinical) and processes. In fact, our research suggests that there was a sense of naivety on the part of the Trusts' management boards, that the merging process would have minimal impact or disruption to services. As a result, in all Trust mergers, external representatives, Trust staff and management reported that senior management had lost control over the strategic direction of the Trust and day-to-day operations at some point in the early phases of the merger. This was often the result of unforeseen circumstances emerging from the merger process itself, and took the form of timetable delays in plans for restructuring and reorganization of services. These in turn were caused by delays in mostly middle-management appointments, by financial shortfalls (mental health Trust, acute Trust and community Trust II), and IT delays, which ultimately set back the organization at least 18 months.

In this study we found that little attention was paid to the perceived cultural differences of the merging Trusts. These differences became more apparent as the merger process developed, and although present in all four case studies, were most prominent in the acute Trust merger. Some respondents regarded the differences in size of the two Trusts, different philosophies and distinct problems at their respective sites as part of an unmanageable barrier between the two previous organizations. The basic incompatibility of the two Trusts has contributed to the whole range of current problems in the merged organization, including the continued tension around directors' and consultants' appointments, organizational structures. In order to begin to address such issues, management teams should recognize that without clear lines of communication, positive working relations within the Trust and across staff groups, these 'clashes of culture' will not diminish. Attempts to address the issue of organizational culture in a merger need to be part of a wider range of improving activities and cannot be in isolation from such issues as: organizational structure, financial arrangements, lines of control and accountability, strategy formulation, or human resource management activities (McClenahan *et al.*, 1999; Garside and Rice, 1994).

In light of the above, critics of mergers have argued that a full merger is not always the only or, in fact, the best option available. In cases where only parts of the organizations need to integrate, alternative strategies such as licensing, alliances, partnerships or even joint ventures can often obtain the same expected benefits but in a less-disruptive manner (Hackett, 1996; Beenstock, 1995; McClenahan *et al.*, 1999; Donnelly, 1999).

A number of lessons can be drawn from the results of our study. It is important to recognize that a merger is a long-term process, from which an organization can take up to two years to recover. Staff should be involved in the preconsultation process from the early stages of the merger, and more transparency and more realism is necessary regarding the measurable benefits and outcomes of the preferred option. Decisions about management structures and strategic goals should be made as soon as possible and with a transparent process. Otherwise, uncertainty and speculation about the future can have detrimental effects on staff and the organization as a whole. A successful integration needs to take into consideration the different cultures of the organizations.

It is of vital importance that the above lessons are incorporated into any future policy considerations or management/leadership agendas about further reorganization within the NHS. Despite political pressures and intentions to make cost savings, managers and leaders within the

NHS need to acknowledge the drawbacks and/or unintended negative consequences that mergers have on the management and organization of work, service provision and staff morale. By ignoring or underestimating the potential backlash from bringing together two or more often dissimilar organizations, managers are creating rather than solving problems. Moreover, in order to achieve a smooth transition, it must be recognized that the merger process is more difficult and time-consuming than is estimated.

Table 13.4 Merged Trusts, Constituent Trusts and Health Authorities

Trust type	*Merged Trust*	*Constituent Trusts*	*Health Authorities*
Acute	Trust A	Trust 1	HA 1
		Trust 2	HA 8
	Trust B	Trust 3	HA 4
		Trust 4	
		Trust 5	
		Trust 6	
		Trust 7	
	Trust C	Trust 8	HA 7
		Trust 9	HA 9
	Trust D	Trust 10	HA 1
	(Case study acute trust)	Trust 11	
	Trust E	Trust 12	HA 5
		Trust 13	HA 10
Community	Trust F	Trust 14	HA 6
	(Case study community trust I)	Trust 15	
		Trust 16	
	Trust G	Trust 17	
	Trust H	Trust 18	HA 7
	(Case study community trust II)	Trust 19	
		Trust 20	
Mental Health	Trust I	Trust 21	HA 2
	(Case study mental health trust)	Trust 22	HA 3
		Trust 23	HA 5
	Trust J	Trust 24	
Combined	Trust K	Trust 24	HA 2
		Trust 25	HA 5
			HA 11

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