NHS Improvement

Guidance for evaluating merger impacts

October 2018

We support providers to give patients safe, high quality, compassionate care within local health systems that are financially sustainable.

Contents

1. About this guidance

Mergers[1] can deliver real improvements in the quality, efficiency and cost-effectiveness of healthcare,[2] but are challenging for trusts to implement successfully. NHS Improvement's previous work[3] found that robust planning is crucial to implementing change successfully and realising the expected benefits. This involves detailed planning for operational delivery and establishing robust processes for monitoring and evaluating benefits post-merger.

This best practice guidance is for trusts that are considering, planning or implementing a merger. It will be useful to trust executives and staff at different levels of the organisation, and specifically those who are leading the merger programme, in planning, overseeing and conducting a merger impact evaluation. It explains:

- how and when to plan an evaluation of merger impacts[4]
- when to do the evaluation and how this fits into the merger timeline
- the key steps for an effective evaluation of merger impacts.

[1] 'Mergers' refer to both mergers and acquisitions.
[2] This could be in the form of improved patient outcomes and experience or service transformation, financial savings and workforce improvements.
[3] Extensive research by NHS Improvement (working with Aldwych Partners and Cass Business School) of the factors affecting the success of NHS mergers has highlighted the importance of being clear about the benefits of a merger, starting the integration plan early and monitoring for realisation of the expected benefits. For our findings see *How to make NHS mergers work better for patients*. Trusts considering a merger should also look at our wider guidance.
[4] In evaluation, 'impact' tends to refer to long-term effects (eg the healthcare system is more efficient) and 'outcome' to short and medium-term effects. For the purposes of this guidance, we use the terms 'impact' and 'outcomes' interchangeably to cover both short and long-term effects.

It is also a useful guide for trusts **when developing strategic and full business cases** for NHS Improvement's transaction review process. It should be read alongside our transactions guidance and used in parallel with existing trust board reporting and assurance processes.

It provides basic evaluation tools and templates that trusts can use to keep track of and evaluate benefits and other impacts resulting from their merger:

- a template that can be used to measure merger impacts at individual service level
- a summary dashboard for reporting the results to the board
- an example of a stocktake report which can be used to inform boards on progress (see Annex 4).

Who this guidance is for

Project management officers – PMOs (or equivalent)	When conducting the evaluation, follow the steps in Section 3.
Integration directors (or equivalent)	When preparing post-transaction integration plans and benefits realisation plans for NHS Improvement's transaction review process. The templates can be used to record and evaluate merger impacts over the identified period. This will likely involve consolidating the information from supporting PMOs into summary reports for the board.
Trust boards	As part of merger planning and business case sign-off. The board stocktake report and summary dashboard can be used for reporting and overseeing benefits delivery post-merger.

2. Overview of the merger impact evaluation

How merger impact evaluation fits into the merger timeline

Merger evaluation has two stages:

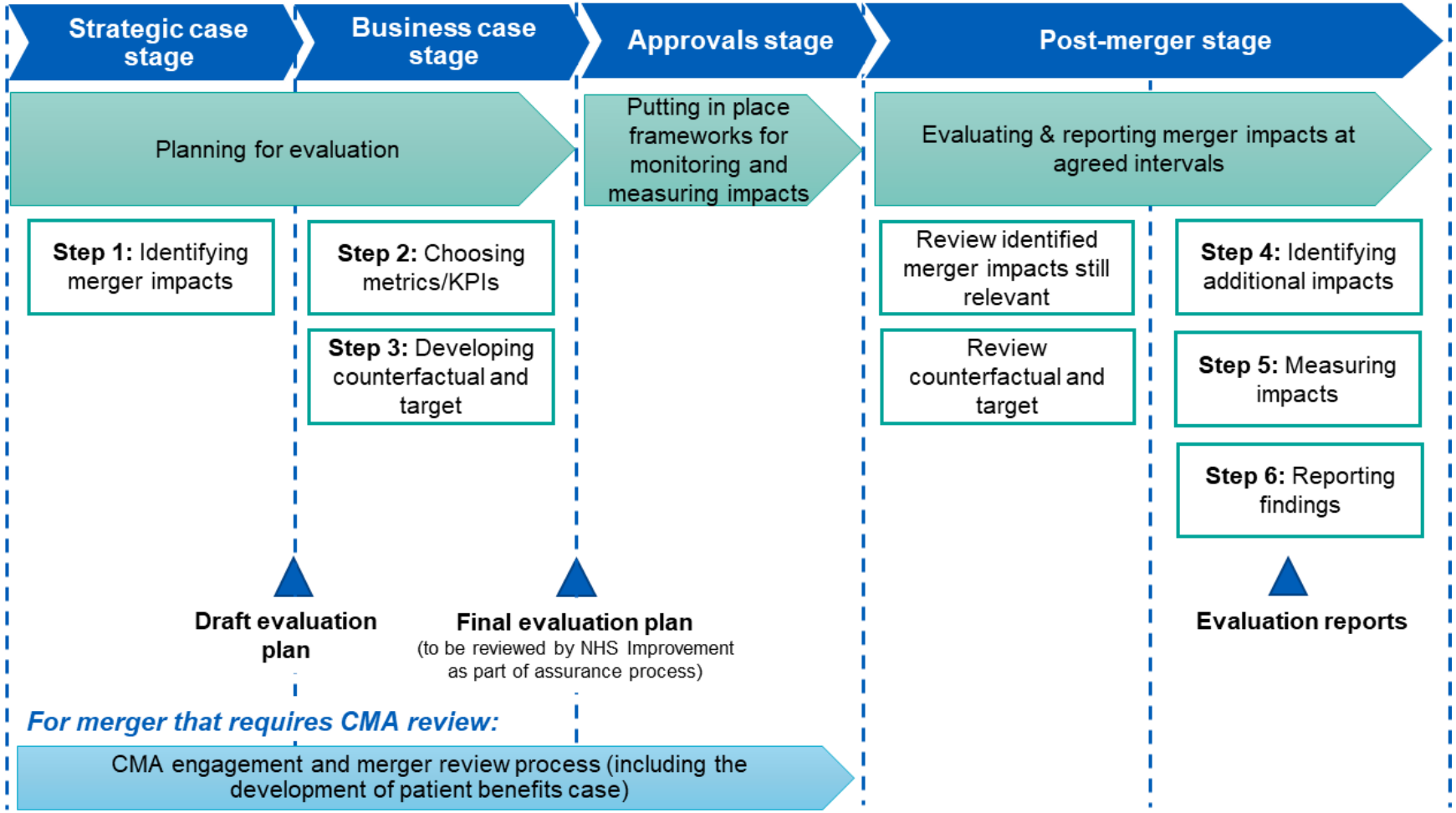
- **Planning for an evaluation** – this involves identifying the key benefits expected from the merger; setting out metrics for measuring the benefits and the benchmark against which these will be assessed (that is, what would have happened in the absence of the merger and the target the trusts are seeking to achieve).
- **Conducting an evaluation** – this involves identifying any additional impacts, measuring merger impacts and reporting the findings.

Best practice for trusts is to set out an evaluation plan at the transaction planning stage (eg strategic and business case stage as described in our transaction guidance). NHS Improvement can help trusts prepare their evaluation plan as part of the merger assurance process. Setting out an evaluation plan before the merger will make evaluating merger benefits for trusts quicker and easier after the merger.

The timeline below gives an indication of how merger impact evaluation fits into the overall merger timeline.

This guidance breaks down the merger evaluation process into six steps; these are explained further in Section 3.

Merger timeline, including merger evaluation



When to do an evaluation

Planning an evaluation

Best practice is to develop an evaluation plan at the same time as the post-transaction integration plan and benefits realisation plan for the strategic and business cases.[5] The evaluation plan needs to align with the overall merger strategy. As when developing your strategic and business cases, a trust should ask early in the planning process:

- What benefits are likely to materialise from the merger?
- How should progress towards achieving these benefits be measured?[6]

Thinking through these questions early in the planning process and setting it out clearly will help trusts build a more robust case for successful merger.[7]

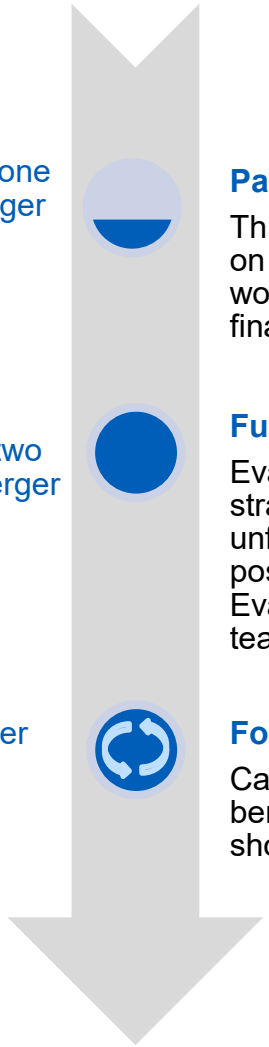
Conducting an evaluation

Trusts should track progress against their post-transaction integration plan (PTIP) and benefits realisation plan on an ongoing basis. Depending on how close the trust is to realising the merger benefits, a full or a partial evaluation can be undertaken:

[5] For mergers where no evaluation planning was done at the merger planning stage, trusts should still try to undertake steps 1 to 3 retrospectively at the beginning of their evaluation.
[6] See Annex 1 for the questions that NHS Improvement expects trusts to address at each stage of the transaction review and that are relevant to planning for an evaluation of merger impacts.

[7] Generally, an evaluation of an intervention involves designing logic models that show how inputs and activities can lead to the intended outputs, outcomes and long-term impacts. This is similar to the process of developing strategic and business cases for mergers.

When to do an evaluation



Six months to one year after merger

Partial evaluation

This takes stock of whether plans are on track and align with the progress being made on the PTIP. Impacts may not be measurable at this early stage, although signs of workforce improvements may be seen in recruitment levels and staff rotas and/or financial savings achieved.

One year to two years after merger

Full evaluation

Evaluation of outputs and outcomes against all the merger benefits identified in the strategic/business case. Trusts should also identify and measure any additional, unforeseen impacts (both benefits and costs). Best practice is to quantify benefits where possible and to comment on progress where these have yet to be fully realised. Evaluation should be shared with the board and regional and central NHS Improvement teams through agreed reporting mechanisms.

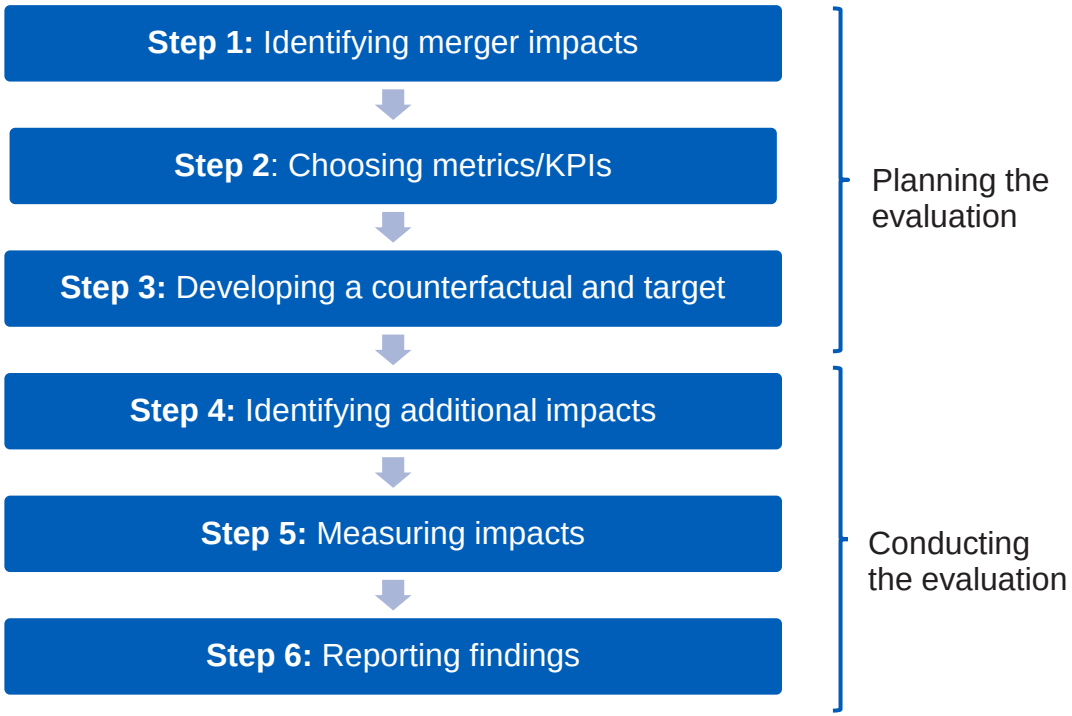
Two years after merger and beyond

Follow-up full evaluation

Can be done if merger benefits are expected to take longer than two years to realise, eg benefits associated with building works or major service reconfiguration. Individual trusts should decide if follow-up evaluation is of value. Any reports should be shared as above.

3. How to carry out an evaluation of merger impacts

This section covers the six steps of the merger evaluation.



Step 1 – Identifying merger impacts

Mergers can affect patient outcomes (clinical outcomes, patient satisfaction, operational performance), and financial and workforce performance. Trusts should identify merger impacts[8] relative to what would have happened in the absence of the merger. Impacts can be positive (eg an improvement in patient satisfaction measures) or negative (eg a deterioration in A&E performance), and intended or unintended.

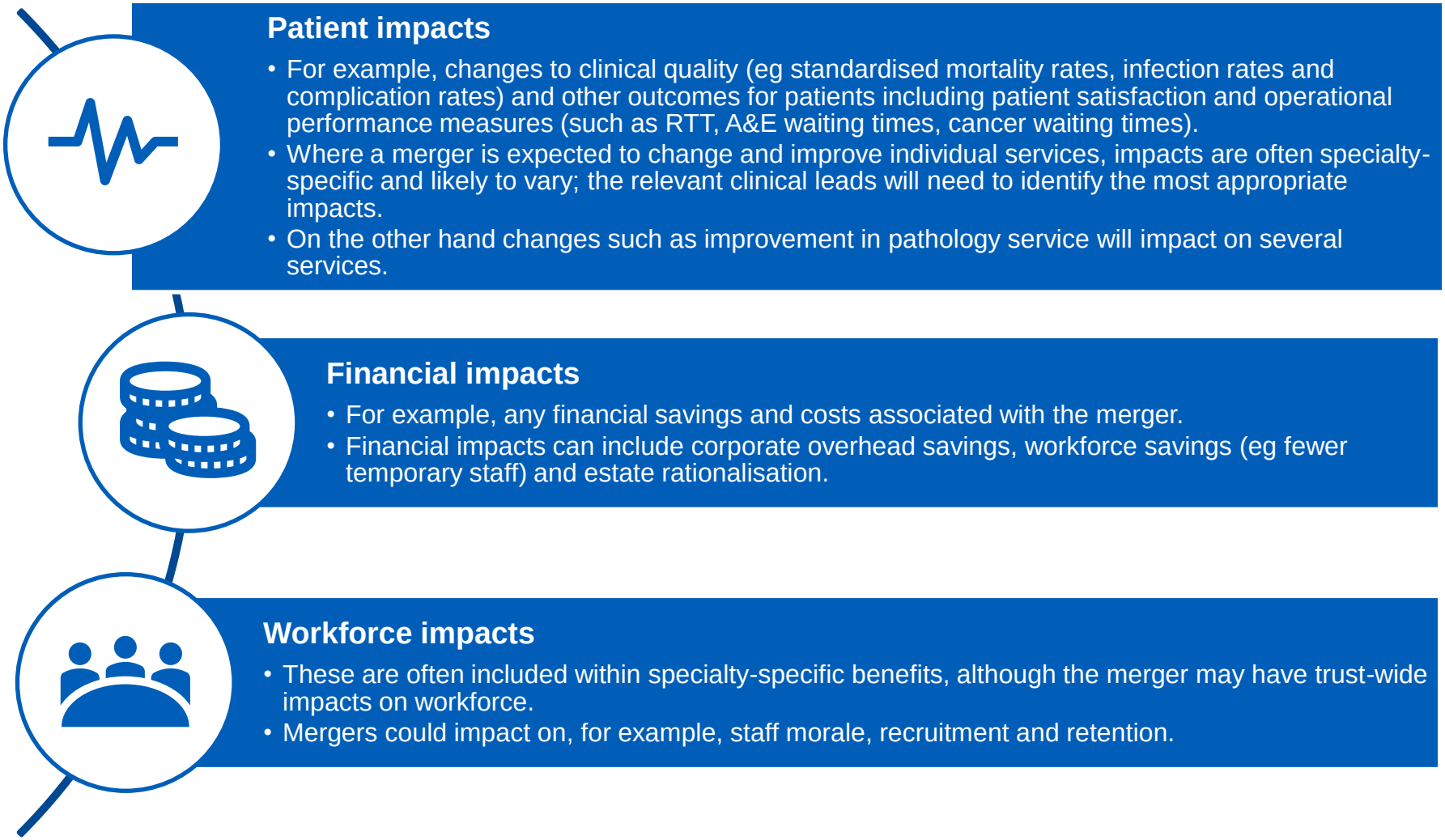
When setting out the envisaged merger benefits in the planning stages, trusts should:

- Engage with a range of their staff and external stakeholders (eg patients, neighbouring trusts, other providers and commissioners) to capture merger impacts during both the planning and post-merger evaluation stages.
- Be as specific as possible to make evaluation easier and more meaningful. This means specifying for each benefit:
  - the change plan to be implemented
  - how this will be delivered
  - the (measurable) impacts expected of the change.[9]

Evidence and experience from past mergers suggests that where the benefits described at the planning stage are too high level or aspirational, they are less likely to be delivered and specific impacts on patients or performance are hard to identify, quantify or attribute to the merger. Likely impacts of healthcare mergers – and therefore a starting point – are listed below:[10]

[8] By which we mean both short and long-term outcomes.
[9] Some transactions could be expected to realise benefits for the acquired trust or the wider health system but may be expected temporarily to negatively impact the acquiring trust's performance. For example, this may happen where the motivation for an acquisition is to turnaround a trust in persistent difficulties. In such cases, it would be useful to specify where in the system the benefits would occur and to explicitly acknowledge the potential impact on the acquiring trust.
[10] *Improvements NHS providers have achieved through merger* gives more examples.

Types of merger impacts



To keep evaluation manageable, trusts should focus on impacts in their benefits realisation plan; they do not need to evaluate every potential impact of the merger.

Some impacts may not have been anticipated early in the transaction planning process. Step 4 covers their evaluation.

Step 2 – Choosing metrics/KPIs

Once key merger impacts have been identified, the next step is to choose the **metrics** with which to monitor progress.

The metrics should focus on **outcomes** where possible (eg increased patient safety, reductions in agency spend, realised financial savings). **Output** measures (eg sufficient consultant cover as a measure of seven-day service introduction)[11] can be used where the link between outputs and outcomes is established, and to confirm that planned activities have happened.

This is particularly relevant where the expected outcomes have yet to be realised.

Their selection should be guided by the following principles:

- consult **relevant specialists** (eg clinical leads for clinical impacts) to explore a range of possible metrics
- ensure that the **metrics/key performance indicators (KPIs) relate to the merger impacts** (eg as overall financial performance may be affected by factors unrelated to the merger, savings in corporate overheads may be an example of a more appropriate metric)
- where possible, use **quantitative metrics** which can be easily analysed and are available for sufficiently long timeframes to allow analysis of longer-term developments
- for impacts that are not quantifiable, a **descriptive commentary** can be provided instead. This may

[11] By measuring outputs, trusts can determine whether, for example, a lack of impacts is because the programme is not working, or because it has not been implemented on time or at all.

include feedback from patients, commissioners and other providers
- choose metrics that are readily available to minimise data collection efforts (such as the Model Hospital metrics)
- consider when impacts are likely to be observed/ measured.

At the planning stage, trusts should identify which metrics will be used to measure each of the identified benefits, with details of: what the metric measures, which time period it covers, and why each metric is the most appropriate measure for the impact (especially if there are a number of options).

Additional considerations for setting metrics for each of the merger impact categories are set out below.

Type of impact	Choosing metrics
Patient	• The appropriate metrics for measuring patient benefits depend on the specialty. **Clinical leads** will need to advise on what is suitable for their specialty. For example, they could be **national standards and metrics set out in existing clinical evidence** (including external reviews such as those from royal college and Care Quality Commission reports). • Appropriate metrics may include **clinical performance metrics** such as standardised mortality rates. Others may be **patient reported outcome measures** (PROMs) or **waiting times**, eg performance against national review to treatment time (RTT) or A&E targets. • Where possible, trusts should also estimate the **number of patients affected** by the service change.

Type of impact	Choosing metrics
Financial	• Appropriate metrics to measure **net financial impacts** are those capturing merger-specific gains, not overall profitability which is often impacted by a range of factors unrelated to the merger. • Measuring financial impacts should capture the cost associated with the merger. Trusts need to monitor the **actual incurred costs** against their planned costs. • Metrics that relate to the impacts of a merger may include: corporate overhead costs, agency spend and merger-related clinical service delivery savings.
Workforce	• Overarching workforce impacts can be measured using **standard workforce metrics**, including trust-level vacancy rates, retention and staff satisfaction. • These metrics can be trust-wide or specific to a specialty.

Step 3 – Developing a counterfactual and target

When choosing the appropriate metrics for each impact as described in Step 2, trusts need to think about:

- what the situation would be in the absence of the merger (referred to as the 'counterfactual')
- the appropriate targets for the expected merger benefits outlined in the full business case and/or patient benefits case and when these are expected to be realised.

Step 5 concerns evaluating the merger impacts by comparing post-merger performance against predetermined counterfactual measures and targets.

Trusts may need to adjust these if the underlying pre-merger assumptions change.[12]

Below are some key considerations for trusts when developing their counterfactual and target measures, but each trust will want to consult its relevant specialists (eg clinical leads) to determine the most appropriate measures.

Counterfactual

In many situations pre-merger measures provide a reasonable estimate of what the performance will be if there were no merger and so can be used as the counterfactual: for example, if performance is expected to stay the same.

But where performance would be expected to change if there were no merger, **alternative counterfactuals** need to be considered. For example:

- Where the financial performance of a trust is expected to deteriorate in the absence of the merger, the trust's financial projections which form part of its business case, approved by NHS Improvement, can be used to inform the choice of relevant counterfactual.
- Where a trust's operational performance is on a downward trajectory before the merger (eg against the national standards for A&E waiting times), it may be reasonable to assume this would continue without the merger (eg due to increasing demand). Under these circumstances, trusts can compare their post and pre-merger performance trajectory. In addition, trusts should also sense check their counterfactual against performance of peers facing similar circumstances. The Model Hospital can help trusts identify appropriate peers.[13] Trusts should explain why the chosen counterfactual is appropriate.

[12] There may be unexpected events that affect trusts' estimates of what would have happened in the absence of the merger (for example, changes to the national policy or funding available to commissioners).

[13] The peers should be trusts that are operating in similar pre-merger conditions as the merging trusts. Their performance after the trusts merge can indicate how the merging trusts would have performed if there had been no merger.

- Where a regional or national event or policy change affects performance of all trusts – such as the introduction of seven-day working, commissioner's change in national specification), the relevant counterfactual needs to benchmark the trust's performance against peers as well as looking at the trust's pre-merger performance.
- Interventions before the merger may affect performance (eg move to joint leadership between the merging trusts ahead of the merger), in which case the pre-merger situation may need to be adjusted accordingly.

Annex 2 provides more examples of developing counterfactuals for different types of benefits.

Targets

As well as selecting a counterfactual, the evaluation plan should specify a target for each identified benefit.

The post-merger evaluation can then assess whether this target has been met as planned.

Best practice when setting targets is to set a specific target:

- be clear about what the target measures (eg unit of measure or a reasonable proxy; the sites or patients it applies to)
- set the time period over which the target is to be met
- set out/explain why the target is appropriate (that is, sufficiently demanding but realistic).[14]

Choice of target is likely to depend on the benefit and requires a degree of judgement. Examples are meeting national standards (eg Sentinel Stroke National Audit Programme measures for stroke services), performance projections (eg outputs from business case financial modelling) or performance of relevant peers (the Model Hospital can help with identifying peers).

[14] Targets could explicitly acknowledge if an acquisition is expected to have a temporary negative impact on the performance of the acquiring trust. This could, for example, be the case for transactions where the motivation for the acquisition is to assist a trust in special measures.

Targets can be set as absolute values (eg fill all vacant consultant posts or achieve a 'good' rating at the CQC inspection in 2018/19), or as a percentage improvement on current performance (eg 10% year-on-year reduction in agency expenditure 2018/19 to 2020/21).

Step 4 – Identifying additional impacts

Each merger carries a degree of uncertainty and risk around its impacts. A merger may have impacts additional to those identified during strategic and business case planning. These could include:

- **Realised risks** – risks identified in the business case that do arise post merger.
- **Unforeseen risks** – new risks coming to light, such as delays from finding asbestos during building works.
- **Unforeseen benefits** – for example, patient benefits from clinicians in the merged trusts coming together.
- **Unintended consequences** – impacts that could not be foreseen at the outset of the merger and were not intended by the merger. These can negatively or positively impact on the trust's activities or the wider health economy.

Where identified, these additional impacts need to be considered in the overall evaluation, to give the trusts and regional and central NHS Improvement teams a complete picture. Trusts can also incorporate any relevant impacts or identified risks into their recognised governance framework and trust-wide audit and risk programme.

See Annex 3 for more guidance on how to consider additional impacts.

Step 5 – Measuring impacts

Where possible, progress should be reported quantitatively against the initial target and counterfactual situation. If the impact cannot be quantified, a descriptive commentary on progress can

be provided. This may include feedback from patients, commissioners and other providers.

The templates in Annex 4 can be used to monitor the delivery and impacts of the merger. Examples of completed templates are provided in Annex 5. Completed templates can be used as supporting evidence when reporting to NHS Improvement regional and national teams at agreed intervals.

Step 6 – Reporting findings

Board stocktake report

Progress against plans should be reported to board at agreed intervals to assure that delivery of benefits is on track and any risks to delivery are being successfully managed. Annex 5 gives an example of what this could look like.

Summary dashboard

Findings from the evaluation should be viewed as a whole and not in isolation. A dashboard is useful for visually tracking overall merger impacts. This can also be a useful tool for reporting progress to trust boards. See Annex 5 for a stylised example of a summary dashboard.

Individual service impact reports

Impacts should be identified and measured at patient and service level if a trust is to fully understand and be assured that improvements from a merger have delivered real benefits to patients. Annex 5 gives an example of what this might look for stroke services.

Annex 1: How impact evaluation fits into planning for a merger

NHS Improvement published transactions guidance in November 2017 for trusts undertaking transactions, including mergers and acquisitions. This guidance sets out a streamlined three-stage process for merger review.

This annex summarises the three stages and gives the **key question trusts need to consider for evaluation planning at each stage.**

The three stages

- Strategic case stage
- Business case stage
- Approvals stage

Strategic case stage

We believe that more attention should be given earlier in the process to **how to evaluate** whether the benefits have been realised and capturing any unplanned impacts – that is, at the strategic case stage. Earlier focus on merger evaluation will make the trust better at monitoring and reviewing performance, and will drive the actions that result in the delivery of benefits.

NHS Improvement expects benefits to be tested as part of asking the key questions in Section 5 of the transactions guidance, and for indications as to the key lines of enquiry to be considered at this stage.

Key Q1: Is the trust's overall strategy well-reasoned and can the board show how transaction supports its delivery?

- What are the key benefits to be delivered from the merger?
- How will the merger enable the envisaged benefits?
- How will the trust review and ensure actions that support benefit delivery are carried out?

Business case stage

We expect further development and review of the benefits evaluation plan at business case stage.

This is likely to include a review of work to develop and agree key metrics, and a counterfactual against which the trust can measure the benefits delivered. We expect the trust to have a clear trajectory and timeframe for delivery of the benefits and to know how they link to the delivery of key actions in the PTIP.

At this stage we also expect to see a clear link from the benefits plan to the trust board and its oversight and governance arrangements, including post-merger reporting and monitoring. We usually probe that there is such a link as part of asking key question 4.

Key Q4: Is there a robust and comprehensive plan for delivery of the transaction, including integration and realisation of benefits?

- What are the key metrics that will be used to measure delivery of the benefits?
- What data will be required for the trust to monitor and track delivery of the benefits?
- What is the counterfactual against which merger benefits will be reviewed?
- How will the trust board have oversight of the benefits monitoring process and wider merger impacts?
- What resource will be required to collate, review and report the benefits evaluation?

Approval stage and beyond

A trust proceeds to the approvals stage once we have issued an amber or green risk rating following our review of the business case. At the approvals stage, we expect an agreed plan to be in place against which benefits can be measured in future.

This guidance includes templates and examples to support trusts with planning for and conducting the evaluation (see Annex 5). These can also be used to report on progress to NHS Improvement if this is an agreed part of the post-merger requirements.

Annex 2: Developing a counterfactual

Below are examples of counterfactuals for each type of impact.

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Type of impacts	Examples of potential counterfactual
Patient	When clinical outcomes are expected to stay constant in the absence of the merger, trusts should use the pre-merger situation as the counterfactual. But if there are reasons to expect that clinical outcomes might not stay constant in the absence of the merger, trusts should consider the alternative approaches set out below. Trusts can benchmark clinical performance against selected peers. For example, the merging trusts may be on a downward trajectory in terms of operational performance (eg against the national standards for RTT and/or A&E waiting times). It may be reasonable to assume that the deterioration will continue without the merger (eg due to regional pressures from increasing demand, or national policies affecting workforce such as seven-day services). Under such circumstances, trusts can compare their performance against their own development trajectory before the merger as well as the performance of peers facing similar circumstances. The Model Hospital can help trusts identify appropriate peers.

Type of impacts	Examples of potential counterfactual
Financial	The strategic case and business case typically include a projected counterfactual financial performance for the trusts in the event they do not merge (broken into the different types of cost savings). This projection, approved by NHS Improvement as part of our merger review, can be a reasonable counterfactual against which trusts can assess their performance after the merger, providing there have been no developments that warrant changes to the assumptions. Financial performance can be further assessed against that of peers. However, such cross-checks should be done on developments in financial performance that are attributable to the merger (eg changes in agency expenditure or overhead costs, subject to data availability). For example, assessing overall performance (surplus/deficit) against a peer group is unlikely to be informative because so many factors drive overall performance.
Workforce	Workforce figures (eg trust-level vacancy rates, trust-level staff satisfaction) before merger for all merging trusts is often a reasonable counterfactual for this type of impact. As variations in the supply of clinical workforce are often regional, benchmarking against regional peers would seem a reasonable cross-check.

Annex 3: Considering additional impacts

The three key steps when considering additional impacts are:

1. Identifying the additional impacts	Additional impacts can be identified as part of: • post-merger due diligence or service reconfiguration processes (these can help identify unforeseen impacts) • monitoring high level performance indicators for board reporting (these can help identify unintended consequences. Trusts can then examine whether these impacts are linked to the merger (Stage 2).
2. Attributing additional impacts	Trusts may be uncertain about attributing some impacts to the merger. A causal link between merger and impact may be easier to establish when the impact is: • directly linked to a merger workstream (eg higher costs due to unplanned expenditure) • indirectly caused by the merger (eg greater patient access to services due to better patient flow management).
3. Tracking, evaluating and reporting additional impacts	Additional impacts should be evaluated alongside merger benefits using the framework described in this guidance, specifically:

- the situation immediately before the merger may again be a reasonable counterfactual unless the impact is in part driven by external factors affecting other trusts as well (in which case the trust should compare its performance against that of peers)
- impact evaluation involves estimating the scale of the impact (eg its effect on performance, financial loss/gain, etc).

Annex 4: Evaluation templates

Our evaluation templates to help trusts with the systematic collection of key information over time are designed to be used flexibly so trusts can adapt them to suit their needs, but we do not envisage they will replace trusts' internal and external reporting.

There are four templates:

- a **data collection form** to help trusts plan for the evaluation and collection of evaluation data
- a **stocktake report template** which can be used to inform boards on progress
- an impact evaluation template which sets out the required information fields (eg measure, target, etc)
- a summary dashboard for presentation of the evaluation findings.

Annex 5 provides examples of completed templates.

Annex 5: Worked examples

Each of the examples of how trusts can provide stocktake updates to their boards and evaluate impacts of the merger based on the principles of evaluation in this guidance:

- sets out the context
- provides a **six-month stocktake report**
- provides a subsequent **evaluation one or two years** after the merger.

Please note that these are illustrative examples only, and the merger impacts they list are not exhaustive.

Worked example 1: Patient impacts – stroke service

Trust X struggled to achieve good outcomes for patients. It failed to meet several national standards and had higher than average mortality rates. Trust Y was higher performing but also failed to meet some national standards. Through merger, the trusts believed they could make improvements for patients that they were unable to achieve independently:

- improved access to medical and therapy input
- improved clinical outcomes
- better patient experience.

These improvements would flow from forming a single stroke team and centralising hyperacute stroke services in a hyperacute stroke unit (HASU). The unit would deliver: seven-day consultant-led ward rounds at both sites; 24/7 stroke consultant-led thrombolysis; seven-day access to speech and language therapists; improved discharge arrangements using early supported discharge (ESD), and seven-day transient ischaemic attack (TIA) clinics.

Implementation of these proposals would be tracked via the PTIP.

Example 1: Six-month stocktake update for board (Note: this stocktake report includes updates on services other than stroke)

Overall summary of progress against plans	Key risks identified (planned/unplanned)	Mitigations and concerns
Good progress is being made for all implementation plans with most on track against timelines. Some notable deliverables and some delayed proposals are listed below. **Successfully implemented** • Seven-day swallow assessments by speech and language therapists in place on the HASU. • ESD for the HASU extended to cover the merged trust's population. This means suitable patients (about two-thirds of those who have had a hyperacute stroke) now receive ongoing support and therapy at home, rather than being transferred from the HASU to the stroke unit. • Increased utilisation of cath lab capacity on site X enables 100 extra cardiac angiographies of patients with non-ST elevation myocardial infarction (NSTEMI) to be done within 24 hours. • Recruitment into key roles (identified business critical gaps in workforce): two radiology and two	The current round of stroke consultant recruitment may be unsuccessful. Unforeseen issues with damp and electrical wiring raised the costs of the estate works to increase the capacity of the stroke unit by £15,000.	Robust recruitment plan in place to ensure trust secures second consultant appointment. Until Sunday clinic in place, any TIAs likely to breach 24-hour target are seen ad hoc on the stroke unit, although patients do have to wait. Medical consultant is supporting the thrombolysis rota and stroke specialist is available by phone if advice is needed. The raised costs for estate works is to be covered from capital budget by reallocating some funds from the planned non-clinical office works.

emergency department consultants plus one orthogeriatrician have start dates.

Delayed or issues logged

- Difficulties recruiting a second stroke consultant are delaying completion of some proposals: Sunday TIA clinic; 24/7 consultant-led thrombolysis; and seven-day consultant-led ward rounds.
- Work to increase physical space at site Y for additional stroke patients is on track but at slightly higher cost.

Merger impact evaluation			
Impact measure	**Target**	**Counterfactual**	**Current position**
Stroke services			
TIAs waiting longer than 24 hours for assessment.	0	70 TIAs per annum at trust X wait longer than 24 hours.	0
Hyperacute stroke patients using ESD.	About two-thirds of all hyperacute stroke patients have a length of stay (LoS) of 72 hours (about 650 patients from among 1,000 total acute stroke patients).	Trust Y: about two-thirds of all hyperacute stroke patients (about 400 of 600 patients). Trust X: none of 400 patients as ESD not in place.	Six-month review April to September: about 450 hyperacute stroke patients have a LoS of 72 hours due to ESD support.

Example 1: Evaluation one year post merger

To measure the **impact** of the implemented proposals, the clinical lead for stroke identified appropriate metrics, each with a counterfactual and target. These are shown below using data for one year post merger.

Merger impact	Impact measure	Target	Counterfactual	Current position (FY2017)	Comment
Patient impact					
Improved access	Number of patients with TIAs waiting >24 hours for assessment	0	70 patients with TIAs per annum at trust X wait >24 hours	0	All patients with TIAs are seen within 24 hours. However, those presenting after Saturday's TIA clinic are seen ad hoc on the stroke unit
Improved clinical outcomes	Number of larger strokes post TIA	0	0	0	Expect 2.7 larger strokes post TIA if patients are not assessed within 24 hours
	Stroke mortality rate	Summary hospital-level mortality indicator (SHMI) ≤1.0	Trust X: SHMI 1.3 Trust Y: SHMI 1.0	1.0	

	Number of patients developing stroke associated pneumonia (SAP)	0	Trust X: 30 patients Trust Y: 24 patients	10	Despite an early swallow assessment and seven-day speech and language therapy support, some elderly and vulnerable patients developed SAP
Better patient experience	LoS for hyperacute stroke patients before discharge home	72 hours for about two-thirds of all hyperacute stroke patients	Trust Y: 72 hours for suitable patients (about 400 of 600 patients) Trust X: average LoS is 14 days for all 400 patients as no ESD in place	Merged trust: 72 hours (about 650 of 1,000 patients)	LoS for hyperacute stroke patients treated at trust X has been brought down to that of those treated at trust Y, through implementation of trust Y's ESD for suitable patients

Worked example 2: Financial impacts – reduction in corporate overheads

Trust X was in financial difficulties pre-merger. The trust had recently reported a deficit of £15 million against a deficit plan of £8 million. Trust Y's management team would bring the necessary governance and financial leadership to improve financial and clinical performance at trust X.

Further, the merger is expected to deliver opportunities for cost reductions, including savings on corporate overheads and reductions in IT. The tables below show a six-month stocktake and one-year evaluation for these financial impacts.

Six-month stocktake update for board

Overall summary of progress against plans	Key risks identified (planned/unplanned)	Mitigations and concerns
The trust has made good progress in delivering the corporate overhead savings through consolidating boards and integrating corporate support functions. The executive directors and external advisors are developing further plans for consolidating corporate support functions but were held up by a two-month delay in appointing advisors. The trust is making good progress with its IT systems and HR integration, with joint appointments and less duplication of these functions. **Successfully implemented** • Single executive board. • IT system integration plan is being implemented, single chief digital officer appointed. • An invitation to tender was published to qualified suppliers (following pre-qualification questionnaire) for a joint theatre system across the trust to support centralised theatres management.	Delays in engagement with corporate support staff during the integration process because of delays in appointment of advisors. IT system integration costs more than expected due to recruitment of additional IT support staff. Further reduction in overhead costs is required to meet financial targets due to additional costs incurred during the IT system integration process.	Additional budget has been secured to meet the IT system integration costs, due to underspends in other areas. Communication plan is being developed to provide staff with more frequent updates on the integration process. The trust is undertaking a stakeholder review next month to get staff inputs into the communication plan.

Delayed or issues logged

- Staff consultation on consolidation of corporate support functions consolidation still under development due to delays in appointing advisors.

Merger impact evaluation			
Impact measure	**Target**	**Counterfactual Current position**	
Financial impact			
Savings through single IT support function and joint IT system procurement.	10% year-on-year reduction in IT operating costs (c £100,000 per annum FY2016/17 to FY2018/19).	Savings calculated relative to FY2015/16 aggregate costs as % of turnover (corporate overheads constant at both trust X and trust Y).	Joint IT systems are being put in place as planned. Savings are expected to be realised one year post-merger.
Savings through unified senior management (board, executive directors).	Board costs reduced by 40% by April 2017.	Pre-merger (FY2015/16) annual cost: £2 million.	A single board has been established across the two trusts.

Example 2: Evaluation two years post merger

This table reports some of the merger's financial impacts two years after implementation.

Merger impact	Impact measure	Target	Counterfactual	Current position (FY2017/18)	Comment
Financial impact					
Generate cash-release savings through reduced corporate overheads	Savings through single IT support function and joint IT systems procurement	10% year-on-year reduction in IT operating costs (c £100,000 per annum FY2016/17 to FY2018/19)	Savings calculated relative to FY2015/16 aggregate costs as % of turnover (corporate overheads constant at both trusts X and Y)	Overall savings higher than expected: • FY 2016/17: £125,000 • FY 2017/18: £110,000 Overall corporate overhead saving is c 1% of turnover	Successful IT systems procurement Clinicians have access to clinical systems across both sites
	Savings through unified senior management (board, executive directors)	Board costs reduced by 40% by April 2017	Pre-merger (FY2015/16) level: £2 million	Board costs reduced by 25%; FY2016/17 level £1.5 million	Unified management structure with a single board, chief executive and senior management generated cost savings of 0.5% of the trusts' turnover

Worked example 3: Workforce impacts – staff retention

Trusts X and Y together have a workforce of over 10,000 staff, including all clinical, managerial and back office roles. As trust X is a small trust that comprises two district general hospitals it has not been able to offer its clinical staff many opportunities for training, specialisation and research. Trust X has therefore struggled to retain clinical staff in the last few years and relied heavily on locum and agency staff. Trust Y, on the other hand, is a large teaching trust that is able to offer staff excellent training opportunities: it has a strong track record in recruiting and retaining staff.

The merger aimed to extend trust Y's reputation and bring new training and specialisation opportunities for clinical staff to improve recruitment and retention at trust X.

Example 3: Six-month stocktake update for board

Overall summary of progress against plans	Key risks identified (planned/unplanned)	Mitigations and concerns
Good progress on recruiting to existing vacancies. Delays in implementing the new training programme at trust X have been due to the greater than expected winter pressures that required significant management input. **Successfully implemented** Engagement strategy to address organisation development, HR workforce and communications. Adoption by HR of trust Y's recruitment practice across the merged trusts. **Delayed or issues logged** Allocation of additional resources for staff training programme.	Further delays to rolling out the training programme. Challenges aligning roles across the two trusts may affect retention/turnover. Continued reliance on agency staff.	Robust plan in place to ensure that the training programme is delivered. Plan in place to align roles and pay grades across the trusts. Internal communication channels are being established for staff to flag any concerns. Agreed action plan with NHS Improvement to manage agency spend.

Merger impact evaluation			
Impact measure	**Target**	**Counterfactual**	**Current position**
Workforce impact			
Turnover rate (clinical staff)	Aggregate merged trust 8% by April 2017	Trust X: 5-year average of 12.7% (pre-merger, deterioration from 10.5% in FY2010/11) Trust Y: 5-year average of 5% (pre-merger)	Trust X: 13% – slight increase from pre-merger level Trust Y: 5%
Nursing vacancy rate	5% by April 2017	Trust X: consistently >20% in the last 3 years Trust Y: <5% in the last 3 years	No change but trust X is expecting to fill several posts in the upcoming recruitment campaign
Survey results on quality of non-mandatory training, learning or development	4.0/5.0 by April 2017	Trust X: 5-year average score 2.3/5.0 Trust Y: 5-year average score 4.0/5.0	No change due to delays in rolling out the training programme
Percentage of nurses with advanced nurse practitioner qualifications	10% by April 2017	Trust X: 3% (FY2016) Trust Y: 10% (FY2016)	No change due to delays in rolling out the training programme
Overall staff engagement score from the national NHS Staff Survey	3.79 (national average) by April 2017	Trust X: 3.70 (FY2016) Trust Y: 3.80 (FY2016)	National NHS Staff Survey results have not yet been released but internal staff survey has seen a decrease in staff engagement

Example 3: Evaluation two years post merger

This table shows examples of how the three workforce impacts can be evaluated.

Merger impact	Impact measure	Target	Counterfactual	Current position (FY2017)	Comment
Workforce impact					
Better staff retention	Turnover rate (clinical staff)	Aggregate merged trust 8% by April 2017	Trust X: 5-year average of 12.7% (pre-merger, deterioration from 10.5% in FY2010/11) Trust Y: 5-year average of 5% (pre-merger)	Merged trust: 7%	Trust X has to reduce turnover amongst clinical staff by filling rotas with permanent staff and providing more opportunities for professional development post-merger.
	Nursing vacancy rate	5% by April 2017	Trust X: consistently >20% in the last 3 years Trust Y: <5% in the last 3 years	Merged trust: 3.9%	Trust X has filled most of its nursing vacancies which has significantly improved staff rotas.
Better clinical staff training opportunities	Survey results on quality of non-mandatory	4.0/5.0 by April 2017	Trust X: 5-year average score 2.3/5.0	Merged trust: 4.2/5.0	The new training programme has been positively received by staff: uptake is much greater

	training, learning or development		Trust Y: 5-year average score 4.0/5.0		than for the previous programme. Staff survey results on training quality have increased, even exceeding the trust's target.
	Percentage of nurses with advanced nurse practitioner qualifications	10% by April 2017	Trust X: 5% (FY2016) Trust Y: 10% (FY2016)	Merged trust: 7%	Trust X has been able to adopt a wide range of resources from trust Y to support nursing advanced practice. While the merged trust has not achieved its target this year, it is expected to reach 10% next year, given the number of nurses expected to be accredited in 2018.
Greater staff satisfaction	Overall staff engagement score from the NHS Staff Survey	3.79 (national average) by April 2017	Trust X: 3.70 (FY2016) Trust Y: 3.80 (FY2016)	Trust X: 3.75 Trust Y: 3.82	Staff engagement scores have improved compared to the pre-merger level but trust X's score is still below national average. Post-merger, trust X has adopted trust Y's training programme and uptake of this has been strong among staff.

Summary dashboard

This example template shows how the evaluation findings (from the examples above) can be summarised in a dashboard. This can be included in a more detailed board-level report as required.

Progress in terms of whether the delivery of a benefit is on track can be colour coded.

G	Planned benefits fully realised
A	Planned benefits partially realised
R	Benefits not realised

There is space to comment on the progress with delivery of the benefit if this has yet to be fully realised.

Where the impacts of a merger were not anticipated at the business stage (that is, additional impacts) but are material, they should be added to the dashboard. The following colour-coding is used in our example dashboard:

G	Positive impact on trust's performance
A	Neutral impact on trust's performance
R	Negative impact on trust's performance

Type of impact	Merger impact	On track?	Evaluation at 2 years after the merger Covers period 2017/18 Comments
Patient impacts	Increased patient safety, outcomes and satisfaction	G	'Good' overall CQC rating in 2018. Trust X saw noticeable improvements in patient outcomes for its stroke service following the implementation of a single stroke service.
	Single stroke team/additional stroke consultant	G	A single stroke team has been established across the two trusts with the recruitment of two more stroke consultants.
Financial impacts	Lower agency spend	A	The merged trust has not delivered the target for agency reduction due to unexpected delays in recruitment and the greater than expected winter pressures.
	Cash-releasing savings	G	The costs and capital spend on merger plan delivery are both below target. Reductions in corporate structure costs exceeded the target. The savings were offset by the higher than planned agency spend.
Workforce impacts	Better recruitment and retention of staff	G	Nursing vacancy and turnover rates have improved with the adoption of trust Y's recruitment best practice.
	Better clinical staff training opportunities	G	New training programmes have strong uptake from staff across both trusts. The number of nurses with advanced nurse practitioner qualifications has increased.
	Greater staff satisfaction	A	Staff engagement score for staff survey is moving towards the national average. A new staff communication programme is being developed to further improve staff engagement.

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