Managing A Merger
The Belfast Story

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Foreword

I am pleased to present this publication as part of the portfolio of the HSC Leadership Centre and our commitment to supporting management and organisation change.

During periods of major organisational change the opportunity to share learning can often be lost as new structures are put in place and individuals with key organisational memory move on.

The following pages capture the actions taken by one organisation in one of the biggest changes to happen in the history of the public sector in Northern Ireland.

This is not an academic study – it’s a workbook that tells the Belfast Health and Social Care Trust story up until 2010 - with useful pointers and reflections on the different stages of the merger – and the lessons that were learned.

Compiled by three experienced individuals in their capacity as associates of the Leadership Centre, it will be of use to a wide range of people. In the first instance it will inform and support those who find themselves in the heat and dust of carrying forward a merger. It will also make interesting reading for new, emerging leaders and it will undoubtedly be of value to the wider public sector as it faces into a new period of change when mergers may well form the basis of service modernisation.

Diane Taylor
Head of the HSC Leadership Centre
Introduction

“Hazardous journey small wages, bitter cold, long months of complete darkness, constant danger, safe return doubtful. Honour and recognition in case of success.”

ERNEST SHACKLETON

“Seen one merger... and you've seen one merger” is the line often used to underline the fact that no two mergers are the same.

This is the story of one merger – a merger of six health Trusts across Belfast, Northern Ireland to create a very large health and social care Trust – values and vision driven, integrated across community and acute care, mental health, adult and children’s social care.

It isn’t an academic document but an honest attempt, warts and all, to tell the Belfast merger story with some reflections that might form the basis of action lists for anyone contemplating such a large-scale venture.

In our story we have tracked the journey from September 2006 when work began on the merger, through to April 2007 when the new Belfast Health and Social Care Trust went ‘live’ and on through the first two and a half years.

You can judge if the merger was a success. Certainly for the authors and for many others it was the most exciting and fulfilling period of our working lives.

A word of caution. Whatever the mandate for a merger - political (as in our case) or to create a broader platform for clinical modernisation or whether it is driven by a financial imperative, think carefully before embarking on a merger. Is your journey really necessary? Can you achieve your objectives by some other means?

The literature on healthcare mergers is scant and not overly encouraging. Fullop and others writing in the BMJ 2002 were critical of acute mergers mainly in London in the 1990s. A more recent KPMG publication in 2011 “Taking the Pulse” was much more encouraging.

Too often mergers seem like the recruitment advertisement placed by the Antarctic explorer Ernest Shackleton; “Hazardous journey, small wages, bitter cold, long months of complete darkness, constant danger, safe return doubtful. Honour and recognition in case of success”.

MANAGING A MERGER - THE BELFAST STORY
In 2007 reorganisation of the health service in Northern Ireland was long overdue. It had seen no major structural changes for over 15 years – something that was remarkable compared with the constant reorganisation that had been taking place elsewhere in the United Kingdom.

There are different views on the reasons for this. In Northern Ireland’s politically divisive climate, defending the status quo in health was one of the few issues on which political parties could share common ground and there may have been a reluctance to introduce upheaval into that one area in which there was political consensus. Direct rule politicians from Westminster were also always aiming to hand over to local politicians as part of the peace process. There were also different opinions on how widely mergers should happen in the public sector. For example trade unions, who had arguably filled a political vacuum for many years prior to devolution, were opposed to the mergers and the creation of fewer, larger Trusts.

But they worked hard to play their part in protecting the interests of their members and the services the Trusts delivered.

Whatever the reasons, the health service in Northern Ireland was ripe for change. The existing structures – 18 Trusts (19 including the Ambulance Trust) served a population of just 1.7m. Separate and distinct, each of the Trusts tended to concentrate inwardly on their own local services. The simple political message skilfully communicated by direct rule Ministers in 2005/06 justifying the mergers was a reduction in overhead costs and an opportunity to reapply the savings to the front line.

There was also tacit recognition that while the leadership team spread across the Trusts had achieved a great deal, it was tired. It was also consumed with operational delivery as it worked to meet growing public expectations, with varying success.
Reorganisation could deliver a reduction in silo working, cut management costs and reduce duplication of services. In short it provided huge scope for delivering a better service to people in Northern Ireland.

At that point Northern Ireland’s much vaunted integrated health and social services were only delivered in four Trusts. The other 14 delivered either acute care or community services but not both. The existing Trusts could be dissolved – and a new managerial structure offering fully integrated health and social care could be established without the need for primary legislation. Instead of 19 Trusts there would be six. The Ambulance Trust would remain as it was – working alongside five new ‘super’ Trusts. The speed of the changes was in marked contrast to the time it had taken to bring them about.

They would come into effect in just over 15 months – with the new Trusts taking managerial responsibility for services and staff from 1 April 2007.

Belfast Health and Social Care Trust was to be formed from the merging of six Trusts - providing comprehensive services to Belfast and Castlereagh Council districts and regional services to all of Northern Ireland with a budget of £1.1billion and over 20,000 staff.

Four of the merging Trusts in Belfast were acute Trusts - the Royal Hospitals. Belfast City Hospital, the Mater Hospital, and Greenpark, and two were community health and social services Trusts serving north and west Belfast and south and east Belfast.

The new Belfast Trust was not only the biggest of the new super Trusts in Northern Ireland in terms of remit, staff and budget – it was also the biggest of its kind in the United Kingdom, employing one in 30 of the Northern Ireland workforce and spending £3m a day.
The Chairman was appointed in April 2006 and the new Chief Executive – formerly Chief Executive of the Royal Hospitals, the largest of the merging Trusts in Belfast – was appointed in July to be in post officially from September of that same year.

The challenges involved in establishing a new organisation in a few months by bringing together six health care bodies – through essentially what could be described as enforced change – could not be overstated.

There was dread and apprehension but also an anticipation that kept those who were charged with the task focused and action orientated.

The new Chairman of the Board of Directors had previously been chairman of one of the merging organisations – and other non-executive directors were also drawn from previous Trusts, bringing with them their experience and a sense of continuity. Appointing one of the Chief Executives of the merging Trusts to the new Chief Executive post inevitably resulted in perceptions of takeover among some staff and presented its own special challenge.

An early decision was taken that the organisations merging to become the Belfast Trust should be referred to as legacy Trusts rather than former or ex Trusts, in recognition of their many achievements which would be carried forward in the new organisation.

Though this may appear to be a small matter, it was in fact very important. In a charged atmosphere like a merger, anything can be seen as a slight and can get in the way of a unified approach.

The new Chief Executive had previously been CEO of the largest acute hospital in Belfast and felt it appropriate that he moved to a more neutral location to better reflect the wider integrated nature of the new organisation.

Had he stayed in his old office during the changes it would have added to the perception of a takeover.

The new headquarters was therefore set up on a site formerly managed by one of the merging Trusts – one that was recognised as having already played a proactive role in providing a range of services in the community.
The merger of Trusts was intended to be the first phase of a major structural transformation of the public sector in Northern Ireland. Regional principles had been drawn up but no practical guidance was available to the merging Trusts.

There were time constraints, the financial environment was worsening, the political environment was changing, managerial capacity had to be reduced and Agenda For Change – the service wide pay and grading system had not been fully implemented.

In the wider environment there were big changes. At that stage of the peace process the newly elected Members of the Legislative Assembly (MLAs) were set to take their seats in May 2007 - one month after the new Trusts came into being – and this would bring a whole new level of scrutiny to the public sector.

It was clear that the financial climate in Northern Ireland was going to get particularly tough. There were indications that budgets would be significantly reduced over the following three years.

This would mean that expenditure per head of the population in Northern Ireland – which was already below Scotland and Wales – would fall below the level of England.

The new management team would have to get a grip on the money from the outset. In Belfast they had inherited an underlying deficit of £50 million; they would have new performance targets and would have to reduce managerial capacity in addition to bringing about a cultural merger – winning hearts and minds.

It was clear from the outset that within the first year the new Trust would have to do something radical to control the money so that the money would not control the Trust. Also - because the health service was the first to implement major change it carried the burden of setting precedents that might be used in other parts of the public service.

Any sensible analysis would have said there were too many factors in the way of doing a merger at this time – but there is never a right time for a merger.

Those contemplating one may for example wish for a stable period but no such thing exists. In the case of Belfast we had to do it – and we just got on with it.

Before the mergers took place there was regional agreement to put vacancy controls in place in the staff groupings likely to be most affected.
This provided more freedom to restructure but it also meant that management capacity in the legacy Trusts was depleted – and the new team inherited responsibility for that risk.

Across all the offices, clinics and wards in Belfast, staff continued to provide services to individuals and families. While there might be changes in location or managers, there would be no reduction in the safety and quality of care.

Health service staff in Northern Ireland have a strong and proud tradition of putting patients and clients first – whatever the upheaval around them – so the impact on individual members of staff was hard to quantify at the time.

To avoid being paralysed by the enormity of the task facing him and his new team, the Chief Executive decided that if everything were to be a priority, nothing would be a priority.

There was no way at this stage in the merger that he could see the whole picture in detail – so he identified the headline achievements that were needed - the big things that could be counted on one hand – and actioned.

It wasn't just a merger to get the merger done – it was a merger as a vehicle for transformational change – a once in a generation opportunity to bring about change for the benefit of service users and also to create an environment that would enable staff to excel.

The Chief Executive and those Directors who had already taken up post before the new Trust went 'live' met the wider group of Directors and their equivalents in the six legacy Trusts to give some initial key messages that would be repeated and repeated over the first years of the merger.

This was marking the end of one era and the beginning of a new one. While acknowledging the loss of what had gone before, it was also made clear that there was now a new regime.

The Chief Executive told the Directors from the merging Trusts that they were at the beginning of a transformational journey not just a cost saving merger. Here was an opportunity to not only deliver better care and support but to improve health and wellbeing and help tackle health inequalities.

Belfast, he said, could be much more than the sum of its six parts. Delivery of safe, good quality services would continue to be the focus of everyone's activities. The bottom line was that everyone was there to serve patients and clients.
The importance of attitudes and behaviours was underlined. Directors would be expected to treat staff as volunteers, not conscripts. Human Resources had begun working on a range of activities to support them and assist with the changes, acknowledging that some might say they did not want to continue to work under the new arrangements.

Transitional arrangements and a timetable for next steps were outlined for the Directors as they looked to what the future might mean for them. For example dates were given for trawls for posts, for applying for voluntary early retirement. What should they now be called?

It was agreed that current substantive Directors who had not been appointed Directors in the new Trust but who still held senior high level posts should use Senior Executive’ as a title and sign Senior Executive for Director or Chief Executive to ensure the continued smooth running of business and administration.

The changes taking place in health and social services – and in the wider environment in Northern Ireland were major. There may have been agreement at high level that changing was the right thing to do but pulling all the strands together, managing the money, meeting new performance targets, reducing managerial capacity, restructuring and bringing staff along with the new arrangements was a challenge on a whole new scale.

Reflections

- There is never a good time to do a merger – you will always have challenging environmental circumstances. Don't let environmental factors be an excuse for not proceeding. In Belfast, against a deteriorating financial situation and in a fearsome political context we treated more patients to a higher standard using fewer beds and made 4% cash saving in each of three years. It can be done!

- The origin of the mandate for a merger can make a big difference. Belfast’s was imposed with a strong political mandate. Other mergers may draw on an internal mandate, which may lead to greater or lesser commitment from all the stakeholders depending on the power of this mandate. This will dictate the speed and enthusiasm.

- Be aware of the need to balance sensitivity towards individuals impacted by the change and the need to push forward with the merger, even where it can impact on those same individuals.
• Consider vacancy controls well in advance for staff who may be affected by the merger.

• Understand that you will have disaffected people. Provide an escape route for those who don’t want to be part of the going forward. For those who are staying on and taking on jobs that may change beyond their expectations, put in place a follow-up – a “How has it been for you?” service to support them in any future choices they might want to make.

• Though often unspoken, a key reason for mergers is to strengthen and refresh the leadership team.

• Is it a merger or an acquisition? You have to accept as a reality that if a Chief Executive is appointed from within the merging organisations it can be seen as a takeover. Carefully thought through actions to mitigate this are required – for example in choosing the location of the new organisation’s headquarters.

• There is always a dilemma to face in merger situations about the tone you strike. You can over assert and destroy the opportunity to win hearts and minds. You can also tread too timidly. There is no right answer – a lot depends on the existing dynamic and culture. The important thing to remember is to be sensitive to this and to the need to balance all the factors, which are present at the time of your merger.

• Choosing a name can be everything to those involved in a merger. In the case of Belfast it was non controversial as it covered a recognised patch. But for many mergers the naming of the new organisation will be an extra sensitive issue requiring careful thought and engagement.

• And finally... in all the frenetic activity leading up to a merger you can sometimes lose sight of the basics. In Belfast the switchboard staff in all the different locations were overlooked. No one had specifically spoken to them about what to say to callers on April 1 when the new Trust went live.

The Chief Executive arranged to visit each of the switchboards to meet staff and agree the way
in which they should answer the phones from day one of the new organisation. He was met with courtesy, respect and large amounts of tea and cakes at each location.

Sometimes you can get so fixated on the higher order things that you forget the things that are important to the people you serve and those they talk to first when they contact your organisation.
The key six months
- setting the tone

“The most important thing is the decision to act – the rest is merely tenacity. The fears are paper tigers”
AMELIA EARHART

This section focuses on the first three months leading up to and the three months immediately after the new organisation officially came into being.

In the beginning you have to do a lot of things at once. You will not do everything but you have to do enough of the big impact things to make the organisation a success – otherwise you never regain that lost ground. Big mistakes at this stage are not easily recovered at a later time. We have seen other mergers where inadvertently signals were given that it was a takeover to the dismay of much of the new organisation.

In getting the process of managing started, the approach of the new Chief Executive was to have a coherent strategic direction that was simple, clear and communicated well rather than having a perfect, completed vision for the future. In striving to make Belfast Trust more than the sum of its parts, his approach was informed partly by his personal commitment to leadership and partly by years of working in partnership with trades unions and others who had demonstrated that both the health service and the community could benefit from Trusts taking a broader view of health. He was convinced that the Trust was not just about modernising services and delivering them.

This was based on the fact that people who experience material disadvantage, poor housing, lower educational attainment, insecure or no employment, or homelessness are more likely to experience poorer health and earlier death than the rest of the population.

Establishing a new Trust that would work beyond its walls as a force for good – with, for example, pre-employment schemes for school leavers and other initiatives was not only good for the community – it was also enlightened self interest on the part of the new organisation.
The higher order purpose of the Trust was established from the outset – to improve health and wellbeing and reduce health inequalities. This would be achieved through the Trust’s main business which was to deliver safe, improving, modern, cost effective services – in partnership with others – and by engaging with staff.

It would not have been appropriate at that stage to launch a completed vision of success for the new Trust but a higher order purpose had the potential to unify people committed to public service while leaving potential critics unable to argue with it.

Engagement with staff, trade unions and community groups was crucial. The Chief Executive began a round of meetings at key locations in the community where he met leading charities, voluntary groups, politicians and other influencers, explaining what he hoped the new Belfast Trust could achieve. He gave clear promises about how the new Trust would work in partnership with other statutory bodies.

This developed into a formal process of engagement culminating in the publication of “Involving You, a framework for community development and user involvement” in 2008. The development of the relationship with stakeholders meant we were able to sustain their trust and confidence during particularly difficult times.

At a series of open meetings in different workplaces the Chief Executive made a number of early promises to staff. He told those who worked for the new Trust that if they would play their part in providing safe, high quality services, meeting access and financial targets he would also play his part. He reassured people who feared for their jobs that there would be changes but there were no plans for compulsory redundancies. He made it clear that the new structures would support integrated services and be based around the needs of patients and clients – not around world famous hospitals or other health care institutions in the city – respected and loved though these were.

He also promised that the new Trust would seek accreditation as an Investor in People, a standard which would ensure that staff would be respected, involved, informed, developed and given recognition for achievements.

The Chief Executive acknowledged that despite best intentions there would be fallout from the changes. Alongside those who wanted to be part of the new merger arrangements there were others who didn’t.
One of the requirements on all the new Trusts was a 25% reduction in senior management and corporate support staff alongside a 12.5% reduction in professional management and a 10% cut in clinical administration support.

Because early promises and simple outlines of the way ahead could only take the new organisation so far, a number of major activities began running in parallel at this stage. These included career direction seminars, recruitment, team development strategies, staff and wider stakeholder engagement.

No single activity was going to push the organisation forward but with enough initiatives firing off at once, it started to gain momentum.

Nadler and Tushman, writing on organisational design, point out that structures, work, people and culture should be attended to during organisational change – and in the final part of their congruence model is the concept of fit. Organisational performance rests upon the alignment of component parts of the organisation ie work, people, structures and culture with all others to ensure congruence. The greater the congruence, the higher the performance.

Each element had its own challenges. For example it was important to ensure that new Directors could move forward with their structures to support the delivery of services but it was also important to achieve the required savings. This was addressed by a set of agreed principles within which Directors had considerable freedom to implement structures that best met the needs of their stakeholders and the delivery of their service. One of the new Directors was also sent to each of the major legacy Trust sites to support business continuity.

The challenge in a merger is not only dealing with the new but also sufficiently acknowledging what has been achieved by the legacy organisations – all with their different cultures. In short you have to end the old organisations to allow a new culture to be developed and also have a good “wake” for the legacy organisations. With hindsight and with more time the new management team in Belfast should have done more in this important area. The organisation was focussed on establishing the new arrangements for integration of services, supporting those who were up for the change and addressing the concerns of a small number of vocal people.

There were a number of key corporate events to mark the passing of what had gone before but amid all the changes there were also a number of individuals who bowed out quietly after many years of dedicated public service and who did not receive the recognition they were entitled to.
Reflections

• Develop a coherent strategic direction that is simple, clear and well communicated. This will focus the individual efforts of many people.

• Ensure that you continuously engage with your stakeholders from the start – especially trade unions. Invest in the relationship and understand your stakeholders needs.

• Expect and require a commitment to personal leadership from your senior team.

• Develop clear, simple organisational values that are well communicated, well understood and required of the organisation.

• View your organisation as a wider force for good. Look beyond the walls to use the corporate might of the organisation as a force for the common good.

• Nothing is a priority if everything is a priority. Make a limited number of key early promises – and deliver.

• Establish key operating principles that you will work to – the organisation’s contract with its stakeholders; even if it is to say “I will tell you what I don’t know”.

• You will be judged on how you deal with the fallout among your staff – and your organisation’s good name may well depend on it. Understand the impact of your people strategy in letting go of the old. The small decisions you make about how to treat people, particularly those leaving the organisation have a disproportionate impact on people’s perceptions of the values of the organisation – what the organisation stands for. Whether this is an organisation they can trust.

• Think some of the small issues through and realise that they will be magnified – for example if you don’t attend leaving events for former colleagues.

• And finally – people will be experiencing a range of emotions at the time of a merger. Sometimes you have to just let that play out. Sometimes there is an opportunity to address it. In Belfast one of the more innovative devices was a Placement Support Unit. Through this it was possible to physically and metaphorically put an arm around people among the top 100 impacted by the merger.
The unit offered advice in a systematic way to help people decide if they wanted to exit the organisation or play a role. It is hard to demonstrate its success but we strongly believed we had a duty of care to people whose jobs and careers could be affected – and there was never a legal challenge to our placement of staff.

At a time of great turbulence and change the Placement Support Unit provided a safe, confidential space for those most directly impacted by the merger.
You cannot over communicate at times of change. Engagement and communication played a big part in establishing the new Belfast Trust with a significant amount of activity already well underway in advance of the merger. Staff and their families, patients, clients and a wide range of other stakeholders needed to know what the new organisation stood for.

As the new Trust’s first priority was to ensure that those using its services would not see any lessening in services as a result of the changes, it was crucial to involve staff and their representatives as early as possible – to tell them what they could expect to see happening, listen to their concerns and be upfront about what wasn’t yet known.

The new Trust would be relying on the people who delivered its services to understand what was happening and to help explain the potential for improvement that the changes would bring.

Sir Roy Griffiths, the former supermarket boss who introduced general management to the health service said the NHS would never have the right relationship with its patients until it had the right relationship with its staff. Belfast Trust set out to establish a tone in communications with staff, which acknowledged that people chose to work for the health service, needed to be treated with respect and needed to know what was happening – even though many aspects of the merger were still unclear.

Updates were provided to trade union representatives through a joint forum with managers. Through this forum the Trust explained how thinking was developing and invited input before decisions were made. This meant that even in the wider challenging industrial relations climate there was regular formal communication alongside more informal meetings.
At a series of more than 60 day and evening briefings – open to all staff – the Chief Executive took questions and undertook to answer those he could not deal with on the spot through a weekly e-bulletin. The bulletin also addressed wider rumours and shared the latest regional developments.

Alongside worries about whether they would be forced to work in another part of the city and whether their part of the service would lose out, a key question for people with mortgages, young families and other financial responsibilities was whether there would be compulsory redundancies. Nobody really knew at that stage. Regionally there had been no guarantees so the Chief Executive could not promise that all posts were safe. But he told staff that in Belfast Trust any requirement to make efficiency savings through staff numbers would aim to be met by a combination of existing vacancy controls, appropriate redeployment and meeting some early retirement requests – rather than announcing redundancies.

While the e-bulletin played an important part in communicating the changes, the face-to-face meetings were a very important element of the process. At times of major change staff want to see and hear the person in charge. The impact of the changes on many of those being merged at times mirrored the different stages of grief – denial, anger, bargaining, depression, acceptance – and for many it was like a bereavement. They had all worked for different organisations which at one time in the 1990s had been in competition with each other – and for many the heart and soul that they put into their public service on behalf of patients and clients was matched only by the fierce loyalty they felt for their disbanding Trusts.

At each briefing the Chief Executive outlined the new Trust’s higher purpose and its day-to-day business. He also underlined its three key messages.

“There are only three things I need you to do” he said “Deliver safe, modernising services, meet the regional targets on access to treatment and care – and balance the books.”

In recognition of the loss many felt because of the changes to their management arrangements, he and the new Directors encouraged the organising of special events and publications to mark the achievements of the legacy Trusts and the people who had led them.

In a personal letter to each member of staff transferring to the new Trust he said he knew that people work in health and social care to make a difference to people’s lives – and that he would always view them as volunteers, not conscripts.

The new organisation’s internal communications strategy grew from the early engagement with staff who made their information needs
clear. A communication toolkit was put together – a framework for cascading information through team meetings and listening to staff’s views. A Corporate Welcome event was also quickly established for new and transferring staff – and in a survey was later acknowledged to be very helpful to new and existing staff in understanding the role of the new Trust.

While the merger of six Trusts in the Belfast area provided the best opportunity in many years to improve services to the public through more integrated working, it wasn’t enough knowing this was the right thing to do – the public and its elected representatives had to understand what was happening. The new Trust had to manage relationships.

Following his appointment – and armed with the Trust’s higher order purpose and remit for integrated services, the new Chief Executive, joined by Directors as they were appointed, held a series of meetings with patient and client representatives, politicians and other key opinion formers to explain what the new Trust aimed to do.

An important framework for external communication was provided by an early community development and engagement strategy drawn up by the autumn of 2007.

The Trust committed to a number of milestones on the journey towards change and promised to keep the community updated on progress towards these through annual conferences.

This, combined with the identifying of other key stakeholders, helped the Trust draw up an annually reviewable Communications Strategy called ‘Getting Relationships Right.’

Reflections

- Start with the basics – purpose, business, and key messages – and remember that when you are tired saying them, some people will only be really hearing them for the first time.
- Identify key stakeholders and begin listening and talking to them about the potential of the new organisation as early as possible. There is no need to wait for everything to be signed off.
- Tell stakeholders what you know – and what you don’t know. You don’t have to have all the answers.
- Make maximum use of e-communication for sharing information or quelling rumours but consider face-to-face communication as a central part of your activities as it always beats electronic communication when you are working to build a relationship of Trust and set the tone for the new organisation.
• A letter to each member of staff is a good investment as it is an opportunity to explain your personal contract with them as well meeting formal requirements.

• Keep communicating – even when there is nothing new to say. People facing the changes resulting from a merger cannot get enough information. They need to know when bulletins will be issued – and what you believe will happen next – even if you are not 100% sure. If staff feel they know what you know they will be less susceptible to rumour and low morale.

• And finally – communication in a merger is not just about the new. Communication teams need to be involved in marking the achievements of what has gone before as part of their work to introduce the new. This includes supporting publications and events that respect and celebrate the past – and its contribution to the future.
One good structure is as good as another. Structures need to satisfy or reach a minimum standard rather than optimise. They need to meet a set of basic principles based on facilitating the purpose of the organisation.

Here are the basic principles drawn up in Belfast:

- Must support organisation in meeting its objectives
- Cross cutting – not based on institutions
- Must focus on added value, pro-activity and professionalism
- Performance management culture
- Improve governance
- Must be affordable
- Involve those it impacts on.

It’s a fool’s errand to try to seek the perfect structure and, as if to emphasise this point, the Chief Executive, when unveiling his structures for Belfast Trust, made a virtue out of this, making clear that the structures would be reviewed in one year as the circumstances of the Trust would inevitably change.

Whatever you do, don’t think about simply decapitating two, three or even six structures and, like some Frankenstein’s monster plan to put one new head on top. You miss the point of a merger if you don’t take the opportunity to ensure the design of your structures not only meets objectives but also makes a strong statement that something is different – something has changed.

In Belfast the structures were designed with the needs of patients and clients at the centre rather than institutions, professional or managerial boundaries. Two examples of this were services for older people and children. It meant for example that the Director for Older People, Medicine and Surgery was responsible for the services older people received whether they
were in general surgery, medicine, on a trolley in the Emergency Department, being supported in their home or local community. Freedom to bias services in favour of non-institutional solutions increased opportunities to provide truly integrated care for older people.

Likewise the Director of Children’s Services took responsibility for services inside and outside hospital for children and adolescents. For legal reasons the Director had to be a qualified social worker – something very new to hospital based clinicians. However paediatricians in the regional children’s hospital, based in Belfast, saw the benefits the new arrangements would have in terms of all children’s services coming under one Director.

In having this drive for a focus on population cohorts the new Belfast Trust team could be criticised for not leaving enough support for individual institutions. Locating Directors of different services at key institutions only went so far as the new integrated approach radically changed the role of each location.

An important feature of the new senior team was the number of Directors – 13. These represented a third of the total that had existed in the legacy Trusts and they had extensive portfolios in comparison.

Overall there were significantly fewer senior posts in the new organisation than in legacy Trusts. To support the changes the Department of Health had run Career Directions workshops for Directors in the legacy Trusts.

These Directors had to think whether the new jobs were for them because they would not just be jobs in a bigger organisation – they would be bigger jobs. They needed to ask themselves “Is this the place for me? Have I the resilience?”

Development centres, sponsored on a regional basis by the Department of Health, and facilitated by people from outside Northern Ireland, were established to help senior people assess their competencies and get themselves ready for the selection process. They were sending out the message that these were important jobs and people had to prepare well.

The pool of applicants for Director posts was most of the public sector in Northern Ireland. At the next level applicants tended to come from health and social care. All the interviews were compressed into a short time frame and Chief Executives from all the new Trusts pooled their resources. This allowed Directors to be only interviewed once for a number of posts and shortened the process overall. (They could indicate their interest in a number of posts.)

This was a period of huge transition. The new Directors had
to take responsibility for the work associated with getting the new Trusts up and running while at the same time covering much of their existing work. There was only three months between the time of the appointment and the time when the new Trusts would officially start so it was a period of frenetic activity.

Approximately a third of the legacy Trust senior management got Director posts, a third were appointed to the level below the level they had previously worked at but with similar responsibility and pay and a third exited the organisation.

Structures don’t stop at Director level. It was decided that the next level would be Co Directors in recognition of the level they were working at and their span of responsibility. In keeping structures under review the Directors were always conscious that Co Directors had a particular range of responsibilities and, while some were moved to other Directorates as part of establishing the new structures, the Directors avoided breaking up Co Director’s areas of responsibility where possible.

Directors, while working within a specific financial envelope, were free to decide the number of Co Directors they required in their service area. Some for example chose to invest more in Co Directors while others chose to invest at the level below.

In practice structures were reviewed to fifth level (8a or the level directly above an officer in charge or service manager) and all posts were filled through competition.

That meant that the first four levels in the new organisation were selected. There was no automatic placing in post.

On the one hand the process was very debilitating and on the other hand it meant the organisation was refreshed and reinvigorated.

In parallel to the Directorate management structures, the roles of Associate Medical Directors, Associate Nurses and Associate Social Workers were established in Directorates where appropriate.

There was heavy investment in clinical engagement and this could be measured by the number of clinicians in a leadership role in the new Trust. Within a year of the merger the number of consultants in a leadership role had increased from one in nine to one in six.

The new structures unsettled some people internally and externally because they had broken away from conventional structures based on professional lines or institutions.

A person’s manager could be in the community or in an institution – not necessarily the building they worked in.

The new teams were encouraged to have team events to establish themselves. Individuals were
facilitated to avail of internal leadership programmes. All of this aimed to increase understanding the role of the individual and team in the new organisation.

Among the key corporate events held in the first six months was a leadership conference which set out to generate an esprit de corps, energise and excite new leaders about the journey ahead of them and allow them to get to know each other. This was also an aid to integration.

Reshaping and reorganising continued, as structures were fine-tuned. Meanwhile performance targets were met, the Trust broke even and services to patients and clients continued.

Structures had been shared with trade unions for comment as they were being formulated. It took much of the first year to complete population of the structures down to fourth level with each level of leadership designing the structures associated with their services.

There was a dilemma about whether to have service Directors reporting to a Chief Operating Officer and meeting at another forum or whether to have them directly accountable to the Chief Executive.

In Belfast the Chief Executive chose direct accountability – with a peer performance system put in place by the Chief Operating Officer.
Reflections

• Don’t waste time looking for the holy grail of the perfect structure. A workable structure that supports human endeavour is enough.

• Be clear what you want your leaders to do. What are the principles that will help meet the objectives of the new organisation? How do you want leaders to act and behave? Are the driven by a clearly understood set of values and a shared vision of the future.

• Never lose sight of the on-going business of the organisation, despite the scale of the upheaval. Deliver safe, efficient services on budget. In Belfast in March 2006 our performance was a great credit to all those in the service who did just that.

• You have to give people the opportunity to compete and support them in whatever decisions they want to take or whatever position they find themselves in.

• Individuals are important but so are teams. New teams don’t work automatically – you need team intervention to help them.

• Structures are populated by people and their capacity has to be aligned to the requirements of the post. Where the alignment is absent you have to find a way to allow people to exit the post with dignity.

• You must have organisational design principles. Ours required a focus on a population cohort or client group rather than professional hierarchies or institutions. Within these principles Directors had considerable freedom to design structures to meet local needs.

• And finally – though it is hugely debilitating, taking the opportunity to fill your structures with the right people through competition is beyond price. Make the effort – it will be worth it. But also be ready to change your structures in the light of experience and changing circumstances.

Notes...
The establishment of a vision of success outlines what an organisation wants to be in the future, usually in a realisable timescale. This, when well articulated and understood can be a source of inspiration to stakeholders who need to understand the endpoint in a planning framework. The vision can set out a shimmering image of what an organisation will look like in terms of achieving success and can also provide the pathway to get to the endpoint and ensure the vision turns into a reality.

The new Chief Executive in Belfast was very clear from the outset that there needed to be a well understood vision of success which set out the purpose or mission of the organisation and what success would look like, underpinned by values that were owned by everyone involved.

It was not enough to understand the core purpose of the Trust. The development of a vision meant that individuals could be empowered to innovate, to take risks within a framework which the organisation would develop with its stakeholders and which would be well understood by all those contributing to its aims.

Belfast Trust’s vision document The Belfast Way was developed in 2008 to run until 2013. In developing it the Chief Executive engaged with individuals and relevant stakeholders from the time of his appointment in 2006. He felt it was important that the mission, vision and values should not be just words but a living document – an articulation of what the Trust was trying to achieve and how this would happen.

In a concise, pocket-sized publication it made clear the Trust’s higher-level purpose and its business, which would be realised through five strategic themes and a series of ‘We will’ actions.

“Where there is no vision the people perish”
PROVERBS 29:18
Purpose:
To improve health and wellbeing and reduce health inequalities

Business:
In partnership with others and by engaging with staff, to deliver safe, improving, modern, cost effective health and social care.

Values:
The development of values should inform the style of leaders in the organisation and the behaviour of staff at all levels to each other and to external stakeholders.

To some values are a soft issue but they are much more important than they first appear because if you follow them through you are expecting people to alter their behaviour – and this goes right to the heart of behaviours in the different cultures that come together in a merger.

A strong sense of mission can excite followers to ensure they proceed along a pathway to continuous improvement. But how that pathway is walked and how managerial actions are achieved can mean the difference between success and failure. The achievement of objectives that leave a trail of havoc will ultimately bring an organisation down.

Values: Involving staff and external stakeholders in setting Belfast Trust’s values was very successful – and helped the integration process across the Trust. Through talking and listening four key values emerged –

- Respect and dignity
- Personal and professional accountability
- Openness and trust and
- Learning and development.
Strategic themes

Having set out the values, purpose and business of the Trust, five strategic themes were identified to achieve the vision. The themes (corporate objectives) focussed on the positive outcomes the Trust would want to see under the following headings:

1. Safety.
This emphasised the importance of safety and quality of health and social care.

2. Modernisation.
This recognised the need to move forward as part of a continuous improvement programme and, in times when resources are particularly stretched, set out the approach to achieving success.

3. Partnerships.
The notion of partnership was established as being hugely important to deliver on the purpose, business and vision of the organisation. It was recognised that only through engagement with partners both internally and externally could the organisation succeed in both understanding and delivering on what was needed.

4. Staff.
This underlined the crucial role of staff in achieving the objectives of the organisation.

5. Resources.
This underlined the importance of making the best use of resources, ensuring appropriate performance management, value for money and productivity.

Under each strategic theme a set of affirmations was developed. The ‘We will’ statements showed the broad actions that would be taken. For example one of 10 affirmations under Safety stated: “We will foster an open learning culture where staff feel supported and where concerns about safety and care can be openly discussed.”

Even in the first 18 months of the Trust it was clear that the Belfast Way was known, understood and playing a major role in establishing the new Trust as an organisation with a clear and separate identity. The annual planning was done in line with the five strategic themes. They were used as a framework in individual appraisals, at the Chief Executive’s briefings and as the basis for every important managerial document. When Investors In People carried out an assessment – ahead of awarding the Trust the IIP standard – there was found to be widespread knowledge and understanding of The Belfast Way.
Setting a strategic direction
The Belfast Way

PURPOSE
Improve health and wellbeing and reduce health inequalities

BUSINESS
In partnership with others, and by engaging with staff, deliver safe, improving, modernising, cost effective health and social care

5 CORPORATE OBJECTIVES

SAFETY
Provide safe high quality effective care
- Standards
- Outcomes
- HCAI
- Continuous improvement
- Assurance

MODERNISATION
Reform and renew our health and social services
- Access
- “Localise where possible, centralise where necessary”
- Service reviews
- Aligned capital plans

PARTNERSHIPS
Improve health and wellbeing through partnership with users, communities and partners
- Citizen centred
- Joint working
- Civic leadership

STAFF
Show leadership and excellence through organisational and workforce development
- Investors in People
- Staff engagement
- Leadership
- Learning & development
- Team effectiveness

RESOURCES
Make best use of resources by improving performance and productivity
- MORE
- Workforce diagnostics
- Process improvement
- Resource utilisation
- VFM
- Performance management

VALUES AND BEHAVIOIRS
Respect and dignity
Accountabilities
Openness and trust
Learning and development

Five years on its strategic themes remain embedded in the culture of the Trust.

Reflections
- Develop a clear, concise vision of success so that everyone knows what you are working towards.
- Invest in articulating a compelling narrative about the vision that provides a clear line of sight between the individual job holder and the aims and objectives of the organisation.

- The chances of success are increased when those who work for the organisation not only understand its core purpose but also have a framework within which to innovate and take risks to bring about improvement.
- Strategies should be living documents. The five strategic themes developed in Belfast became established in everyday working as the five pillars. They formed the basis of the performance management system, the Chairman’s annual awards for excellence, agendas,
appraisals and the annual report.

- Establish organisational values in partnership with internal and external stakeholders. It will help create a new identity for a merged body. It can also mean the difference between organisational success and failure.

- And finally – a clear vision for the future is an adjunct to leadership – so much so that the Chief Executive would often say: “If it’s in the vision document – The Belfast Way – get on with it. You will almost certainly get forgiveness for trying – and you might even get recognition and reward. If it’s not in the vision document – don’t do it.”
Maximising outcomes, resources and efficiencies

“Manage the money or the money manages you”

We have previously counselled against doing mergers to secure financial viability – two turkeys rarely make an eagle. On the other hand a merger does release some comparatively modest overhead costs and economies of scale but much more importantly it provides a broader platform on which to reorganise and integrate clinical and non-clinical services and so increase patient value. Mergers have the potential to increase public benefit for less public cost.

The Comprehensive Spending Review (CSR) in Northern Ireland set out in 2007 for the three years 08/09 to 10/11 provided a chilly financial climate for the newly established Trust. CSR required £92 millions or 9% real cash saving over the three-year period. Other challenges were unfunded cost pressures and an underlying deficit totalling £50 million.

As an aside it’s worth noting that in NI there is no opportunity – even if it was a prudent course of action – to trade out of financial difficulty.

Robust costing models are used in NI not to develop a tariff but to bear down on costs.

The Chief Executive and the Finance Director debated the merits of declaring a “crisis’ only a few months into the merger but preferred to take some pre planned short term measures and develop a strategic approach building on their shared experience of a previous formal “turnaround” process. It was clear that such an expenditure reduction could only be delivered through a robust, formal change programme embedded in the Trust’s performance management framework and agreed in partnership with the Trust’s key stakeholders.

The Finance Director and her team developed a Trust wide organisation reform programme given the snappy title MORE, standing for Maximising Outcomes Resources and Efficiencies and deliberately emphasising the underpinning patient benefit approach to be taken. One of its slogans was “the
right person doing the right thing in the right place”. The MORE programme fitted with the purpose, business and strategic direction of the Trust as set out in the Belfast Way and the Trust wide services strategy document “New Directions” discussed in the next chapter.

The Trust used the following guiding principles for its short and long term reform and modernisation programme:

- Improve health and wellbeing and reduce health inequalities.
- Focus on prevention of illness, early assessment and intervention.
- Focus on individual needs and choices.
- Provide safe high quality effective care.
- Improve accessibility to services and promote equity and welcome diversity.
- Localise where possible and centralise when necessary.
- Integrate services through partnership working.
- Provide clear directions to services reducing fragmentation and delay and.
- Maximise utilisation of assets.

It was formally launched at the Trust’s first annual Leadership Conference for the organisation’s top 120 leaders in November 2007 – some 8 months into the merger.

An early key decision was how much central resource to devote to the MORE programme. Some GB Trusts had used the equivalent of one person for every £2 million to be saved in a turnaround process.

It was agreed that this change programme was essentially a line management responsibility supported by existing HR, Strategic Planning and other staff – and driven by a comparatively small number of key Finance staff providing information and analysis, collating and monitoring performance.

The Trust established governance, accountability and reporting arrangements within the context of the organisation’s overarching codes of conduct and accountability. The Chief Executive was the Senior Responsible Officer for MORE and gave his personal commitment and leadership. A Programme Assurance Board (PAB) chaired by a non-executive Director from the Trust’s Board of Directors and with commissioner representation, met every two or three months and had responsibility for overseeing the programme, assuring its plans and targets. At first this Board had been chaired by a recently retired English Strategic Health Authority Chief Executive to give independence and legitimacy and provide confidence to commissioners but non-executive Directors from the Trust’s Board felt this was an abdication of their
The PAB received reports from the MORE Steering Group, which had responsibility for planning, and delivery of MORE chaired by the Deputy Chief Executive, meeting monthly and comprising Directors and Co Directors from the service and corporate groups of the Trust.

Cross cutting work stream groups were established by the Steering Group matching the key themes of the programme – workforce, hospital process reform, hospital and community interface reform, strategic service reform, and technology. Each service group – women’s and children’s, mental health, cancer and specialist medicine surgery and older people had their own steering group to identify and address issues and risks, share experiences and challenge performance against their devolved targets. In this way a tight matrix structure was main streamed into the Trust’s overall business and performance management framework.

A comprehensive risk assessment review was carried out on the MORE proposals and plans to deliver targets. This covered the scope and managerial effort required for each proposal, stakeholder interests, the wider health economy, and the availability of revenue and capital for “spend to save” schemes. The Trust struggled to find such resources. Some schemes were given a lower priority or abandoned and in turn other schemes had to be developed. In this way the MORE programme took on a dynamic and evolving nature, especially as alternative models to the delivery of services and patterns of care were explored. At the outset several hundred individual schemes were generated and monitored centrally. It’s all about granularity – that is to say it has to be like muesli – made up of lots of different bits. Many economy, efficiency and effectiveness proposals will not be acceptable or will stall and fail to deliver – so there has to be a continuous process to generate replacement options.

Key stakeholders were staff and trade unions and the commissioners and the wider health economy. There was comprehensive communication and consultation at Trust level led by the Chief Executive and Director of Human Resources and intense negotiations at service group level with trade unions with some flexibility shown about individual schemes and their timing with in the non negotiable targets. There were several linkages with the wider commissioning agenda to ensure that individual proposals were harmonised with revenue and capital service priorities and investments.

Not surprisingly the emphasis in the 2008/09 first year was on workforce controls especially those available from the merger process. The three-year total target
savings of £122 millions was slightly front-loaded to give a first year’s savings of £43 millions of which £30 millions or 3% turnover came from workforce. Over the three year period 1.3% of turnover was saved from senior staff and their administrative support costs directly from the merger. A further 1.4% was released through harmonisation of staffing levels, grades and skill mix across the newly merged Trust.

A key driver for clinical efficiency and effectiveness was to set a target to be in the top quarter of performance compared with peer groups in other GB specialties for patient length of stay for each of the 40 or so bed holding specialties across the Trust. This proved to be a demanding target that many specialties struggled at first to deliver. Experts in LEAN Six Sigma and other process reform methodologies trained staff in partnership with the region’s leadership centre to assist clinical and managerial teams to deliver this target. It released over 150 beds across the Trust. This caused much public controversy and we struggled to get a message across to the public and political representatives that with these fewer beds we continued to treat even more patients to arguably higher quality standards as measured by our significantly lower mortality readmission and complication rates as compared with English peers.

In turn these bed reductions gave head room for the comprehensive review of clinical services and proposals for change as set out in the Trust’s “New Directions”.

Reflections

- Have a formal, branded, organisation – wide process with a clear methodology. Don’t leave it to Finance alone.
- Take a value-based approach.
- Consider the help of an external “critical friend” and ensure non executive directors are holding the organisation accountable for the process and outputs.
- Good quality information is essential.
- It’s all about granularity. Ensure a continuous flow of replacement options.
- Very little will be achieved without full engagement with internal and external stakeholders.
- Be sure to close the circle and hold budget holders to account for agreed targets.
- And finally – embed the savings process in a wider organisational development strategy. Don’t have it separate and stand alone from the responsibilities of line managers. Adopt a matrix approach using a core Finance project team and line managers who are responsible for resources and delivery.
The prime and most legitimate reason for embarking on a merger is to refresh the community of leaders and begin the journey of building an improved culture for the new organisation. A merger kick starts an organisational development process. It also provides a broader palette on which to modernise and reconfigure clinical services. In Belfast within the first year the Director of Planning and Development and a small team had begun work on a new strategy for the delivery of care and by the end of 2008 a major consultation called New Directions was underway inviting a conversation the citizens of Belfast on the future delivery of health and social care services in the city and beyond.

As outlined earlier, Belfast was formed from six Trusts - four of which were acute – the Royal Hospitals, Belfast City Hospital the Mater Hospital and Greenpark – and two Community Health and Social Services Trusts serving north and west Belfast and south and east Belfast. With an effective catchment population (excluding regional services) of less than half a million people, Belfast inherited three emergency departments two obstetric units and three in patient mental health facilities.

Like many cities in these islands (Leeds and Sheffield spring to mind) Belfast’s two large acute facilities the Royal and the City Hospitals had emerged from two different backgrounds, Georgian and Victorian city philanthropy and the Workhouse infirmary. Some work had been done over the previous twenty years to reduce duplication. For example a new regional cancer centre had been built on the City Hospital site and the Royal Victoria Hospital

“Boldness has genius, power and magic”

GOETHE
(sharing a campus with the regional maternity and children's hospitals) was designated as the regional trauma centre. Nevertheless with an effective catchment population of just under 500,000, both retained an emergency department and acute surgical take-in arrangements. There is also a small acute hospital with emergency and maternity departments - the Mater Hospital with a background in the Roman Catholic Church, and Musgrave Park Hospital - a rehabilitation campus also housing a large elective orthopaedic centre. The new Trust also inherited three inpatient mental health units and a community estate of over 100 facilities of mixed quality.

Belfast was also fortunate in benefiting from an investment in seven Wellbeing and Treatment Centres serving natural communities of 50,000 or so and on arterial routes that were evolving into “Darsi” type Polyclinics.

New Directions and its reform of delivery of health and social care was informed by the Belfast Way - the Trust’s mission document and it complemented MORE the wider organisational reform programme aimed at maximising outcomes resources and efficiencies. The challenge for the Trust was to set out a strategy for an overarching and unified health and social care system for the population it served, reducing unnecessary duplication and fragmentation of services and better signposting of services – a pattern of services centred round people and communities and less on institutions.

The consultation document took a stage of life approach setting out a broad direction of travel and answering questions such as “where do I go in the future if I need support because I am an older person.” Similar questions were answered for maternity, children’s, physical and sensory disability, learning disability, mental health, and acute services. The Trust undertook to have a second stage consultation on specific service change proposals.

A key principle was to localise services where possible and centralise where necessary. People more easily access services when they are delivered locally and standards can be assured, while specialist services can often be improved by the concentration of expertise and experience required to deliver the highest possible levels of clinical care.

The Trust also acknowledged that if the higher order objective is to improve outcomes in health and well being and yet health and social care contributes no more than a third of well being, then the future must involve closer collaboration with other statutory agencies, the voluntary and community sector and citizens themselves. We were sure that working in partnership would lead to more appropriate care and treatment improved outcomes,
a better experience for users, improved health and wellbeing for communities and greater social inclusion.

A huge effort was made to engage the full range of our stakeholders from meeting the NI Assembly Health Committee to presentations in small community halls. For example we were badly bruised by an engagement with carers who felt rightly that their role was not sufficiently recognised in our proposals. The response to the consultation notwithstanding, this error was a positive and became a sound foundation for a series of specific service proposals. The favourable response was due to the intellectual rigour of the review, sustained energy and the quality of the engagement process.

The Trust’s wider organisational reform programme MORE, among other targets required the 45 or so clinical bed using specialities to each deliver a bed usage in the top quarter of a basket of peer group specialities across England. This released more than 150 beds to create head room to ease the reorganisation of clinical services across the city.

The consultation proposed the centralisation of inpatient obstetric services on the Royal Victoria site and the development of a freestanding midwifery unit in the Mater Hospital. In mental health care the Trust agreed, following the consultation, to centralise inpatient beds onto one site and reduce the number from 154 to 112. In acute care the strategic direction was set out for the four main sites. Emergency services such as cardiology would be retained at the Mater, City and Royal Hospitals but with a greater differentiation of services to improve patient care and complement the separate clinical identities of the three sites. The Royal Victoria would further develop its major acute role with trauma emergency services including 24-hour primary angioplasty. The City Hospital would further develop cancer and renal services and be the major elective centre including elective orthopaedics. The Mater would retain a range of acute services and would become the site for regional ophthalmic services.

Though strictly outside the time frame of this study it’s worth noting that follow up specific service consultations led to the centralisation of obstetrics and the establishment of a midwifery unit at the Mater in 2012. In 2011 ENT inpatient and outpatient services and vascular inpatient services previously on both sites were centralised onto the City and Royal Victoria Hospitals respectively. Gynaecology inpatient services previously on all three acute sites were centralised on to the City Hospital in 2011 and urology inpatient and day case services previously on the Mater and City Hospital were centralised onto the City Hospital.
Reflections

• Service re-profiling will almost without exception be part of a merger process. Why waste a good merger.

• Selling your proposals will not be enough. It must be an engagement process. The conversation leads to understanding.

• Any proposals for change, modest or radical, will require huge energy and effort so be bold and make it worthwhile.

• Clinical and professional champions for service change make the difference between success and failure.

• And finally – don’t underestimate the impact on individuals and groups within merging organisations – and their ability to resist change, especially if they have been working for organisations or institutions that traditionally were in competition with each other. If you can structure the new organisation around population cohorts and client groups – and involve the individuals and groups in the development of new arrangements you can transcend conventional disputes and reduce the likelihood of resisting change.
Was the merger a success?
Certainly by all the measures available the answer must be yes. More demanding access targets were met, more patients were treated to higher standards of safety and quality, and 4% cash savings were achieved each year for the first three years of the merger. Perhaps most significant of all, the new organisation was a firm basis for a radical re-profiling of all health and social services across Belfast. Conventional thinking is that all change including mergers experiences a dip of performance in the middle as an old regime or regimes, tried and tested, are replaced by the new uncertain and unknown order. No allowance was made for this expected dip by purchasers and system regulators and more demanding targets were expected of the Trust from day one. It was a great credit to staff that no performance fall off was evident.

The new Trust also quickly gained credibility and legitimacy from its external stakeholders ranging from a vibrant third sector to Northern Ireland’s new devolved government and its 104 members of the Assembly. No mean feat for a huge new organisation replacing six local organisations and spending an eighth of the total NI devolved budget.

What were the success factors?
Probably and rather matter-of-factly we simply did enough of the basics to reach a tipping point where the whole enterprise shifts from the old regimes to the new higher performing organisation. Perhaps more subtly we did enough basics also to keep things in balance and aligned across structures, policies, people and culture in the new Trust. Ours was not a simple decapitation of the Boards and top teams of the merging organisations to be replaced by a new team.

Closing Reflections

“Getting started, keeping going, getting started again – in art and in life, it seems to me this is the essential rhythm not only of achievement but of survival, the ground of convinced action, the basis of self esteem and the guarantee of credibility in your lives, credibility to yourselves as well as to others.”

SEAMUS HEANEY
Appointing through competition and interview down four organisational levels to a new cross cutting structure was hugely debilitating and disruptive but was a key success factor. So was our emphasis on continuous team development during the first months and years.

As for the senior team, the experience of us all was of high team synergy, cooperation and even passion for the journey we were on. This generated a camaraderie, a ‘can do’ approach and an energy that sustained us through the challenging times. We have no doubt this was a key success factor.

Whatever your circumstances, whatever your team, a great deal can be achieved through people if you take the right approach. The Chief Executive often used the following quote from Goethe. “Treat people as if they were what they ought to be and you will help them to become what they are capable of being.”

The reliance on a clear well articulated vision to drive the new organisation forward was also critical. The Belfast Way was inculcated throughout the whole organisation and was central to realigning the Trust. Its timing and development was equally important. It did not emerge Old Testament style to be imposed on the fledgling organisation but developed over the first year from the Chief Executive’s mantra to staff at the 60 staff briefings “there are only three things I want you to do; deliver safe improving services, meet the access targets and balance the books” and his commitment to partnership working and achieving Investors in People. Each of these points developed into the five pillars of the vision. Perhaps most important of all we didn’t have a strategy – we did a strategy. It is equally valid nevertheless to do a pragmatic even contingent plan to get through a merger crisis and then in calmer waters do the vision process. We had the experience and brief political space to begin with a vision.

We worked hard on symbolism and language. For example having a neutral location for the new Trust HQ, using the Co Director title to describe those reporting to Directors (often former Directors in the “legacy” Trusts) and giving equal prominence to “citizen” along with patient or client to describe users to emphasise their rights and responsibilities. This all contributed to signalling the type or organisational behaviours we were seeking. We were uncompromising about the behaviours we expected and required of all staff knowing that attitude changes would then follow.

We had an exceptionally demanding timetable with most work on the merger not starting until six months before going “live”. This was turned into an advantage by forcing a pace that required decisions to be made and implemented without second thoughts and generated enough
energy to overcome the huge inertia inherent in such a large merger. We are not convinced that having more time would have added much to the success of the reorganisation. In fact having too much time might mean running out of steam losing momentum and failing to overcome the inertia. There is no doubt however that this pace was too much for some staff at all levels who didn’t have enough time to grieve for the loss of their old organisation and adjust to the new order. This early punishing pace set by Directors and their top teams couldn’t be sustained and it was difficult to calibrate the best sustainable work output and some senior staff found they could not cope with their new roles. For us all it felt too much like still building the plane while flying round a stadium filled with radio “shock jocks”.

We overcooked the emphasis on a cross cutting structure focused on disease processes or population cohorts because this would impact most on the patient experience at the expense of institutions or sites. We inadvertently disassociated ourselves from proud institutions to the extent that we alienated some people who felt abandoned and neglected. With hindsight a matrix structure combining a user and geographic focus would have served better. We continue to debate the decision to bring top management and clinical services together at Director level all reporting to the Chief Executive. We had a stepped increase in clinical involvement in the new Trust but would we have been better to have had range of clinically led service groups held to account by a smaller cadre of Directors?

Prosaically but importantly we did not adequately archive the administrative records of the old organisations or secure empty buildings. We should have paid more attention to saving the past for future interested parties.

A merger is a process not an event. There are no sunny uplands. Success brings as many challenges as failure. The real challenge is not doing a successful merger but securing continuous change that supports a developmental journey, keeping pace with changing needs and expectations.

Good luck and over to you!