



UNIVERSITY OF
BIRMINGHAM

SCHOOL OF
SOCIAL POLICY

Health Services Management Centre

Partnering for Improvement:

inter-organisational developments in the NHS

Final Report

DR ROBIN MILLER & DR ROSS MILLAR

Acknowledgements:

The authors wish to thank the Health Foundation for funding this project and for the support from Tim Gardner and Donna Buxton.

We would also like to thank the research participants for their generosity with both time and insights.

Contents

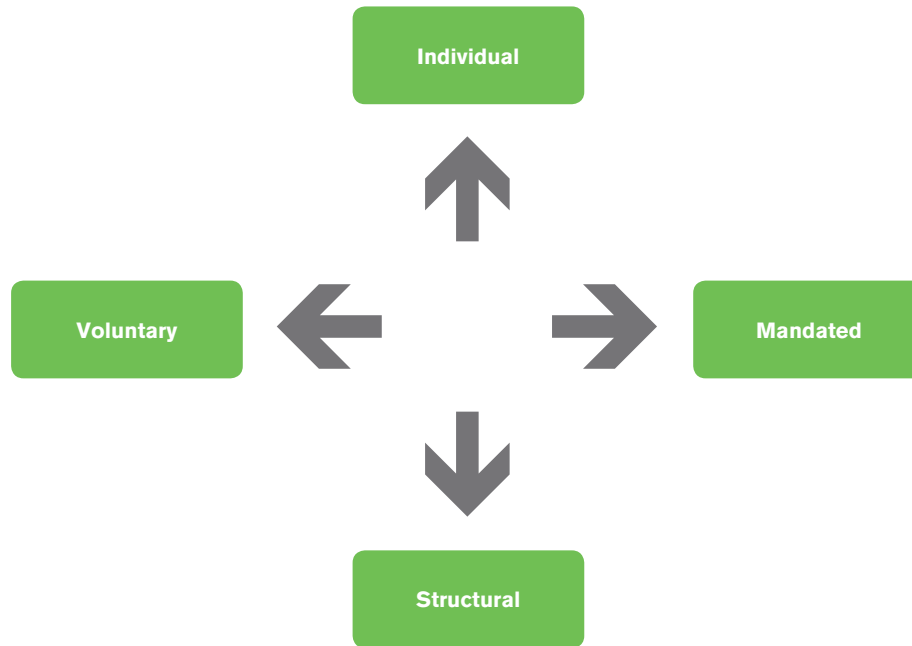
	<i>Page</i>
EXECUTIVE SUMMARY	4
INTRODUCTION	6
WHAT DO WE ALREADY KNOW ABOUT PARTNERING?	8
PARTNERING BETWEEN NHS PROVIDERS: CURRENT ISSUES	10
CASE STUDIES OF PARTNERING IN THE NHS	12
□ Case Study A: Voluntary Partnering between Riverside and Valley High	13
□ Case Study B: Mandated Buddying at Green Bay	16
□ Case Study C: Enforced Merger between St Phillips and Rowheath Park	18
□ Case Study D: Voluntary partnering between Southside and Diagnostic UK	22
□ Case Study E: Voluntary merger between Greenpoint and Middleton Way	25
HOW DO WE SUCCESSFULLY PARTNER?	28
CONCLUSION	32
REFERENCES	33

Executive Summary

Partnering between NHS providers has been promoted by policymakers and organisations as a means to improve local healthcare systems.

It takes many shapes and formats, with key variables being the scale of the partnering and the underlying motivation for entering into such arrangements.

Diagram 1: A typology of partnering



This research explored the expectations and realities of partnering across these different spectrums (see Diagram 1). It suggests that partnering of all forms – including those that are mandated – can provide a good foundation for improvements in quality. The research identifies the following key learning from across these arrangements:

- Individual partnering can provide a cost-effective means to introduce new practices and enable mentoring and reflection for those tasked with leading improvements. It has the potential to tap into the intrinsic motivation of those involved, as well as drive entrepreneurial activity, innovation and energy into improvement efforts.
- Structural partnering can facilitate more fundamental and sustained change across organisations and systems. It is dependent on the appropriate alignment between providers regarding the capacity and diversity of skills appropriate to local contexts.

If such factors are not in place then structural partnering can be a costly diversion from other opportunities to improve, with any partnering unlikely to be sustained or spread to other service areas.

- Mandated partnering by regulators can make a positive contribution to the recovery of a struggling organisation. To achieve success, a careful assessment of the factors underlying poor performance is required alongside sufficient capacity and relevance of the suggested partner to respond to these factors.
- Mandated partnering requires time to bring about improvements and a coherent improvement strategy embraced by all stakeholders.
- Voluntary partnering builds on the intrinsic interests of those involved which can enhance buy in. However, even with shared interests and vision, investment in appropriate co-ordination and governance is required to ensure that activities are planned and benefits are realised.

No-one form of partnering is therefore better as the potential costs and benefits of each option require careful assessment in light of the context and objectives. Leading and managing partnering builds on intra-organisational skills but does entail additional complexities due to alternative processes, accountabilities and cultures. In any partnering there will be key individuals whose ability to collaborate and trust each other will be crucial. As ever, data to understand process and impact is vital but is often problematic across organisations. Environmental challenges can make or break partnering even if there is otherwise a good fit.

Our research identifies a range of implications of relevance to all those with an interest in pursuing partnering NHS providers.

- Partnering Options: There is a spectrum of partnering options available that all have their relative strengths and weaknesses.
- Partnering Selection: The fit between partner organisations is important with care needed to ensure sufficient alignment of objectives.
- Partnering Leadership: Boards and executives are instrumental in setting the tone for a partnership. Sufficient space and resources are required to support those tasked with putting partnering into practice.
- Partnering Competence: Each partnership is unique but each one also requires a common set of skills including practical co-ordination, negotiation, value mapping and impact monitoring.
- Partnering Costs: Partnering can result in benefits for all concerned but no matter what the scale of the arrangements there will be a cost. This may be additional resources to provide oversight and development but most commonly relate to the diversion from other activities.
- Partnering impact: Monitoring of impact is needed to understand whether expected benefits are being met. Given the challenges of measuring such efforts, shared discussions about appropriate measures are needed as well as how these are to be analysed.

- Partnering termination: In view of the actual and opportunity costs, and the changing contexts in which providers operate, such relationships must be reviewed periodically to ensure they still deliver required value.

Our research identifies a range of implications of relevance to policymakers and regulators:

- Partnering scope: A systemic view is required which considers the dynamics between organisations and the shared potential for improvement rather than the failings of of an organisation in isolation.
- Partnering framing: The benefits of connecting an organisation which has challenges with aspects of quality with one that is stronger in these aspects may be lost if the relationship is framed as one being 'a failure' and the other 'a success'. A more balanced terminology which reflects the systemic nature of such issues reduces a loss of morale and a feeling of being dominated by the other organisation.
- Partnering flexibility: Each situation and context requires a bespoke partnering approach, and the contribution and receptiveness of each partner will also vary. Encouragement to explore different options and pursue the most suitable is beneficial. Regulators can play a helpful role through providing guidance regarding such options.
- Partnering expectations: Partnering is able to deliver real benefits but this is not always the case. There will be organisations and localities for which partnering is not the most appropriate solution at this point and instead organisations should be working on their internal processes and capacity.
- Partnering oversight: Sufficient time and resources need to be given for partnering to address instances of poor quality. This is likely to be the order of years rather than months. During the transition period alternative governance may be helpful to bring together the various stakeholders and minimise duplication in reporting.

Introduction

Partnering between health care providers is increasingly seen as an integral component of a quality health and care system. This applies not only in England, with all the home nations promoting the benefits of greater collaboration, but also on the world stage as part of a movement towards more co-ordinated, person centred care. Partnerships can take many different shapes and forms. They build through trust and mutual respect when patients are at the centre of decision making and professionals share their expertise and resources. They develop through inter-professional working and care co-ordination between services and organisations. They reside within communities of practice that provide effective peer support between those with a passion and interest in working with a particular population or area of service. They occur when organisations seek to find 'collaborative advantage' through the sharing of good practice and improvement capacity with other potential partners.

There are many phrases to describe such activity – collaboration, co-ordination, integration and so on, but all these have at their heart the willingness to work with others to achieve a common outcome. The ethos of such partnering is embodied in the Five Year Forward View vision of an NHS built around the new models of care (NHS England 2014). It can be identified in the 'delivery vehicles' for NHS provision as set out in the Dalton Review (Dalton 2014) as well as the emphasis on 'place based planning' underpinning the development of Sustainability and Transformation Plans (STPs).

Partnering can also found in approaches to performance improvement by health service regulators. The 'special measures' regime introduced in 2013 and administered by the Care Quality Commission and NHS Improvement draws on partnering approaches to improve services and organisations that are deemed to be failing to meet expected levels of quality.

This includes a 'buddying' relationship in which a stronger (as measured by key performance ratings) organisation provides support through releasing key staff to provide mentoring, training or direct leadership to their counterparts. Partnering includes instances where concerns are such that regulators have brokered mergers of two organisations with expectations that organisational practices can be more fundamentally altered for the better. Such interventions start from a different premise to the notion of voluntary partnerships where a mandate requires one or possibly both organisations to participate with the expected outcome being set by an external party – the regulators – rather than the contributing members. Despite this very different beginning, it is still hoped by regulators that the end benefits of partnering will be realised as the individuals concerned and their institutions begin to work together.

Whatever the starting point and scale for such partnering, it will need to overcome several common barriers in order to achieve successful change management. Previous work by the Health Foundation (2015) suggests these include a lack of recognition that change is needed; a shortage of capability to successfully make changes happen; limited motivation for change; and insufficient 'headspace' to make changes. A partnering arrangement introduces another level of complexity to such change. Not only for example is there the issue of supportive cultures within the organisations, but also the need for good cultural fit between the organisations. Management responsibilities may be uncertain in joint projects where leaders from one organisation are unlikely to have credibility earned from previous engagement with the workforce in the other, and influencing strategies may not transfer to other staff groups and contexts. Data may be difficult to pool and then understand, and the necessary financial and human resources may not be forthcoming if the arrangements are perceived as being more in the interest of one partner over another.

This project, funded by the Health Foundation and undertaken by the Health Services Management Centre at the University of Birmingham, examines partnering between health care providers as a means to achieve service improvement. It is based on a series of interviews with NHS policy stakeholders and the experiences of five case studies which have been selected to reflect the continuum of partnering – mandated and voluntary, individual and structural.

It reports on the realities of such arrangements from the experiences of those involved. It also reflects on the key learning generated from these insights to understand the success factors needed for any partnering arrangement.

Nature	
Mandated:	Partnering that has been brokered by a body outside of the organisation such as a regulator.
Voluntary:	Partnering that has been instigated by the involved organisations.
Scale	
Individual:	Partnering that primarily occurs through a limited number of individuals or services within the partner organisations.
Structural:	Partnering which is of larger scale and more formally constituted. This could include mergers, acquisitions and contractual agreements.
Form	
Merger:	Partnering where two organisations combine their resources to form a new organisation.
Acquisition:	Partnering where one organisation becomes subsumed by another.
Buddying:	Partnering where individuals or organisations with more experience help, mentor, advise, or train others.

What do we already know about partnering?

Partnering can encompass a spectrum of arrangements. As a result, the literature cutting across this research incorporates a variety of different arrangements: from structural partnering through to individual buddying arrangements.

Previous studies of structural partnering have primarily been interested in organisational mergers and acquisitions (eg, Weil 2010, Gaynor et al 2012). Increased efficiency, economies of scale and market presence are often presented as the key assumptions that motivate such transactions. Despite the common sense logic that greater scale should be more efficient, there is a reasonable body of evidence that suggests that such economic benefits are rarely achieved in practice. Research regarding quality (both patient experience and improved clinical outcomes) is less common, with a mixed picture suggesting that mergers and acquisitions can lead to a reduction in quality or at best only progressing in some aspects of the expected areas (eg, Protopsaltis 2003; Curtis 2005 et al; Vogt & Town 2006; Demers 2013; Kings Fund 2015). Recent studies provide helpful case study data from NHS trust mergers (Aldwych Partners 2016 Cass Business School 2016) with a range of service improvements reported from service consolidation (in which activity and /or expertise was concentrated in fewer locations); strengthening of care processes; investment in estates and infrastructure; improved recruitment; and increased research and development. Increases in volumes of activity through greater scale is also linked to improvements in quality (RAND 2014), although performance improvements against national outcomes are still to be determined (Cass 2016).

All studies agree that realising financial or quality benefits from mergers of health care organisations is far from straightforward and often takes years to materialise, if ever. The scale of the task is commonly under-estimated, in particular, the challenge of bringing together different and potentially clashing organisational cultures (eg, Field & Peck 2003, Demers 2013, Weil 2010).

Research suggests that the approach to addressing such cultural factors should vary depending on the basis of the merger. A 'merger of equals' model requires strong engagement from clinicians and other staff groups to jointly identify and create shared opportunities from the best of both partners. However an 'acquired model' is thought best served by the leading organisation setting a detailed action plan of how they will act to strengthen the other post-merger (Aldwych Partners 2016). It has also been highlighted that there can be negative impacts on the emotional wellbeing and motivation of staff groups during the transition process which need to be considered (Fulop et al 2005, Castner et al 2015). Whatever the starting point and approach a clear sense of the overall purpose of partnering and the anticipated benefits are key (NHS Improvement 2016) and must be accompanied by a willingness to implement the more challenging aspects (McKinsey 2012).

Interest in individual buddying builds on its potential to bring about change and improvement through peer support (Ehrich et al. 2002). Studies in this area predominately take psychological perspectives to show how buddying between two individuals – in the form of sharing experiences or advice – has the potential to provide much needed support and opportunities to learn for both parties.

The most notable example of this comes from Nigah et al (2012). These authors review the literature as part of a wider empirical study of the impact of buddying on psychological capital and work engagement. Their summary of the field shows how buddy schemes have the potential to forge new relationships (Williams 2006), with positive associations between buddying and work engagement (as measured by energy, dedication and interest) and psychological capital (as measured by confidence, optimism and resilience). As with buddying, evidence regarding peer mentoring also shows a positive impact for the individuals involved. For example, Ragins et al (2000) observed significant positive associations between satisfaction with peer mentoring and job satisfaction, organisational commitment, and organisation-based self-esteem.

When we turn to healthcare, the literature on buddying and mentoring in healthcare reflects these trends. Often limited in scale and scope, these studies present largely positive accounts of such arrangements, limited to the individuals involved. Roueche and Hewitt (2012) document the results of a series of 'Beyond Audit' workshops, highlighting enthusiasm from junior doctors and managers to buddy in relation to service improvement work. Ahmed-Little et al (2011) and Kadir and Nazir (2011) report the success of local 'meet the manager' initiatives. Kadir and Nazir (2011) document how these 'unique and simple' events had a positive impact on the relationship between senior management and junior doctors, providing them with a platform to bring about and implement new ideas and discuss issues.

'While buddy schemes are popular across occupational sectors, there is little academic research available on the effects or effectiveness of buddying.'

Partnering between NHS providers: current issues

Senior NHS stakeholders highlighted that, whilst there is a current policy interest in exploring new models of partnering within England, there has always been formal and informal partnering between individuals and organisations working within the NHS. Examples of such arrangements might include the professional networks developed by clinicians and within supply chains for the securing of goods and services. It was recognised that, going forward, partnering would continue to be a key dynamic within the NHS and that it would be an expectation that all provider organisations would be looking at how partnering could improve their own, and others', services.

‘In the past being a really successful organisation was all about shoring yourselves up almost in a fortress mentality and it doesn’t matter if the finances in the local economy have gone completely down the toilet and it doesn’t matter if other providers locally are struggling. As long as your A&E isn’t clogged up and your balance sheet looks good then that’s great,’ and I think we’re not in that place anymore. We don’t want to be in that place anymore so we want to really reset what it means to be a successful organisation.’

CHIEF EXECUTIVE

Partnering has a ‘common sense’ appeal which can be seen to respond to the collaborative values held by many in the NHS. However, it was equally recognised that it can be hard to achieve such potential benefits of partnering in practice. A lack of clarity on the purpose within the providers concerned and indeed commissioners or regulators requiring such arrangements was a common problem. The local rationale and the expected benefits will be different for each partnering and participants were not confident that NHS organisations always had a sufficiently sophisticated understanding of how to assess and map out the opportunities and challenges. Such informed decision making is vital, as all partnering involves a substantial commitment of time and resources. It was also suggested that NHS organisations often entered into partnering to respond to a problem. This was contrasted with private sector healthcare providers in which such alliances were commonly developed as a means to build capacity and diversity to exploit or develop an opportunity for expansion and growth.

‘One of the main bits of learning we’ve had from it is that we need to be much more explicit about our expectations. I think we were just hoping, naively maybe, expecting that the two organisations would sit down together and start to build a relationship and figure out what it was that they could help with.’

POLICY LEAD

The lack of equal access to informal relationships between clinicians, largely due to 'old boy (and indeed 'old girl') networks', was also raised. This poses a difficult balance where established relationships are an important component of individual partnering but if networks exclude those of a particular gender or educational background (eg, going to the 'wrong' medical school) this can unfairly limit such opportunities. This also has negative impacts on patient care as people who do 'not fit' may not have the opportunity to share innovations and develop necessary collaborations.

A number of other factors were raised as being likely to affect the success of partnering arrangements. These included the geographical distance between partners, the strength and openness of existing relationships, and the individual and organisational experience of partnering in general. The willingness of the key players to engage with the opportunity was crucial. The challenges of being the 'stronger' partner in mandated partnering arrangements were frequently raised. These related to demands on capacity and diversion of attention from in-house pressures and also the lead organisation believing that they had the necessary skills and experience. The complexity of acting as the lead partner and the associated risks to their own performance meant that it could be a challenge for regulators to identify organisations to take on this responsibility.

'Where buddying has worked well, the chief exec of the partner organisation has personally been very involved with the chief exec and the executive team as well as the broader organisation that they're supporting... They've spent time at the trust with the executive team or the board. They have deployed other members of their senior team like maybe the medical director or nursing director to go and provide coaching, mentoring, actual hands on support. There has been a real cross fertilisation of ideas and really hands on, practical support.'

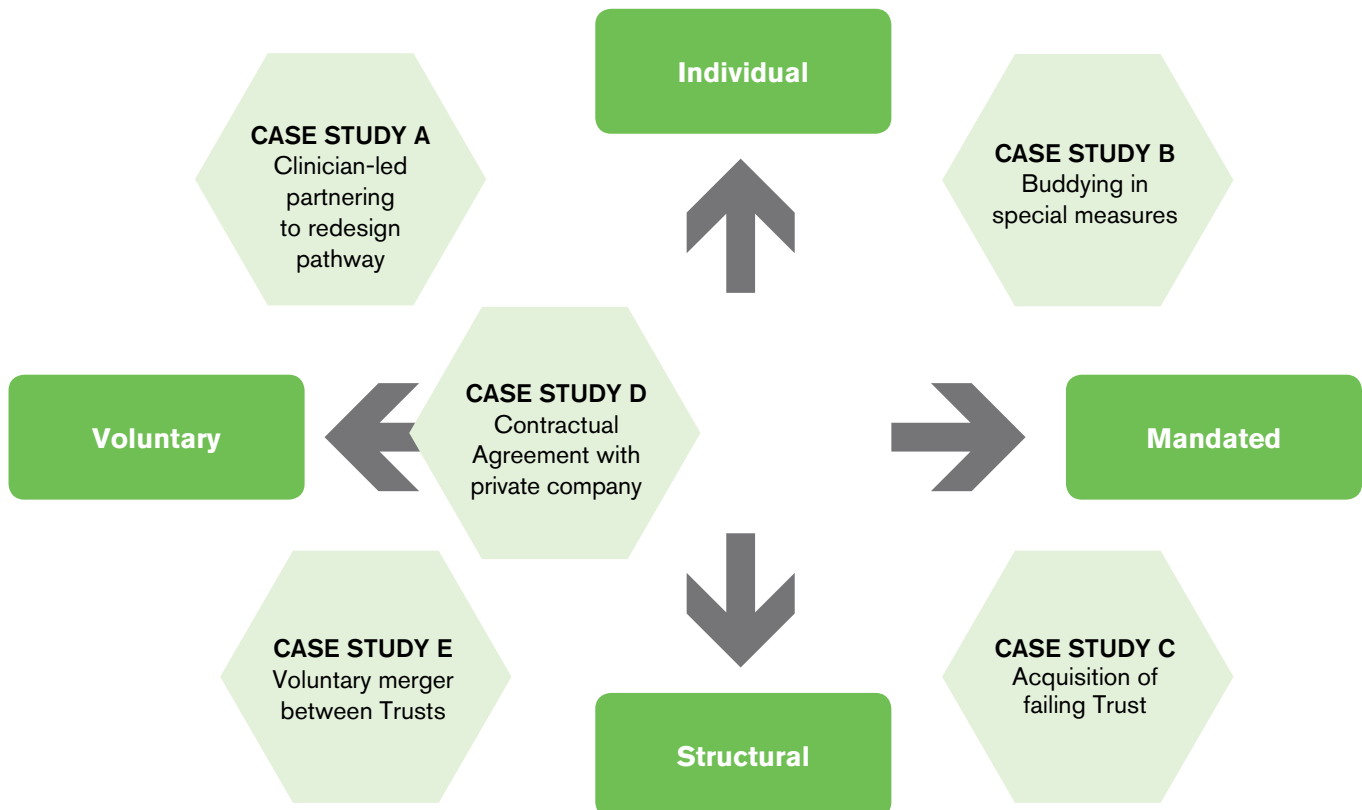
REGULATOR

Case studies of Partnering in the NHS

The results of our interviews with NHS stakeholders suggest that current strategic thinking regarding partnering in the NHS reflects the learning from research: high expectations of what partnering can achieve, some experience of positive benefits, and a complex set of factors that can enable or prevent such benefits being realised. To understand how successful partnering could be more consistently achieved we worked with five current case studies in the English NHS. These were selected to reflect the key variables of partnering outlined above – voluntary or mandated, individual or structural (Diagram 2). Interviews were completed with 10–12 key individuals within each of the case study sites.

These included representatives from 'board to ward' comprising executive directors, senior managers, clinicians and support staff to gain a range of different insights. The interviews were semi structured in looking to examine perceptions and experiences regarding the 'partnering journey' and the factors that led to any successful improvements in quality.

This section presents a summary of each of the sites and the learning obtained from their partnering journeys. In order to fulfil ethics and research governance requirements, and the wishes of some of the participants involved, the case studies have been anonymised.



Case Study A: Voluntary partnering between Riverside and Valley High

Traditionally patients at Valley High district general hospital who required home ventilation were transferred to Riverside for home ventilation. Due to demands on the specialist service (Riverside), patients were experiencing waits of several weeks when they were otherwise ready to be discharged. As well as an inefficient use of resources and negatively impacting on performance, these extended stays were highly frustrating for patients who wished to return home. It also placed them at risk of picking up hospital-based infections, and meant an in-patient stay of several days, some distance from their local area and their informal support networks.

Partnering response

A new partnering arrangement was jointly instigated by the consultants in the two trusts who separately came to the same conclusion that with a shared care pathway they could address the delayed transfers. Valley High would identify patients who may benefit from home ventilation and undertake the necessary diagnostic tests. These would be shared with Riverside and the appropriate equipment and settings agreed. The patients would then be discharged home with a subsequent overnight stay at Riverside to confirm that the equipment was suitably configured and they were confident in its use.

Leadership was provided by the two instigating consultants. Their leadership was built on their status within the organisational structures and clinical expertise. Other team members held them in good regard as clinicians and as individuals and agreed with the vision behind the partnering. They were therefore willing to take on the role of 'followers'. The lead consultants in turn recognised the vital contribution played by their colleagues and were supportive of others taking on responsibilities for implementing and improving the initiative. The leads had a strong relationship as individuals and were happy to share the leadership role and any praise or indeed work that was connected with this responsibility.

Their relationship had developed through the Consultant in Valley High being trained within the specialist service in Riverside. Other consultants within the two services were less engaged in the development of the partnering but were now following the new processes for relevant patients. Both doctors were seen as competent and sensible clinical leaders by senior managers which gave wider organisational credibility.

A meeting was arranged in the early days of the partnering with the relevant operational managers from both Trusts to ensure that they were aware of what was being proposed. The proposed alliance between the Trusts was not a driver of the partnering but did still provide a supportive context.

'It was a Saturday. I remember sitting down, just scribbling it down, and then I saw the patients waiting were from Valley High, and so I just wrote an email one Saturday saying "Do you think we could do this?" and he said "Interesting, I was just going to write the same thing to you."'

CONSULTANT

Each service expressed pride in the work of their individual teams and a strong commitment to improving the experience of patients. They also described separate traditions of seeking to introduce new improvements and working with other departments and organisations to bring about such changes. This included acting as 'social entrepreneurs' who could communicate the benefits of a new practice to those who may be initially unclear of its potential value and to secure necessary resources. Existing relationships between key staff within the services helped to consolidate the partnering arrangements. Both services appeared confident in what they did and in the work of each other. This enabled Valley High to be open to feedback on how they could undertake their new responsibilities, and for Riverside to maintain clinical accountability despite the practical work to instigate home ventilation being undertaken by the other team. The overall description was one of shared endeavour in which both parties had a part to play and in which neither was seen as the stronger player.

'He genuinely does have a commercial head, he's a very good researcher and he's a good clinician. That combination is rare... He also realises he's not an expert in everything and will just say "is this ok, is that not ok, is this a completely mad idea?"'

OPERATIONAL MANAGER

Managing the partnering

Implementation of the new arrangements was shared between identified nurses, doctors and technicians. They were largely confident in each other's competence to undertake the necessary actions and respond to any snags that arose. It was though an informal arrangement, with email trails rather than electronic referral systems, and a reliance on individual interest and responses to ensure that all necessary tasks were completed. The limitations of this approach was recognised, particularly as Riverside was looking to setting up similar arrangements with other Trusts which would increase patient numbers.

The technical skills connected with the changes were largely present although additional knowledge regarding the home ventilation equipment was required by Valley High's nursing staff. This had been gained incrementally through discussions with the more experienced staff in Riverside. There were also some concerns that Valley High would benefit from further training and despite this being offered it had not been taken up as yet. No formal improvement methodology was deployed to guide the partnering and during the first 12 months there had been no collective review of the arrangements and what could be strengthened. This was seen as potentially valuable but difficult to arrange due to other work pressures. All of the partnering activities were carried out within existing workloads of the staff members concerned. This meant that whilst the key tasks were being completed it was difficult to undertake developmental work to strengthen and sustain the arrangements.

‘We don’t ever have a kind of debrief over what we’ve done whether someone was the right person to refer or what we could have done differently. We don’t have that at the moment.’

TECHNICIAN

Impacts of the partnering

Twelve months on there was little formal analysis regarding the impact of the partnering. The available data related to basic activity (ie, number of patients supported) rather than outcomes (ie, what difference it had made). This was recognised as a gap with a planned clinical audit commencing when sufficient patients had been through the new pathway. This was begun by a medical registrar on rotation but then required further analysis by the clinical leads which was proving difficult to fit in alongside other responsibilities. Evidence regarding the outcomes for patients were therefore more anecdotal in nature but never the less suggested that some individuals were benefitting.

The services planned to carry on with the new home ventilation arrangements and Riverside was looking to roll out with other hospitals for which it provided specialist support. The potential risks of relying on informal engagement were recognised with plans to include the pathway within the mainstream processes. Regular opportunities for the key individuals within the services to review and therefore improve the arrangements were being organised. Analysis of the clinical audit was due to be shared and means to provide more on-going performance data being explored with operational managers.

‘I think the patients have benefited, you know, they spend less time in hospital and more time at home and I think that’s really important. Remember, that’s the reason why we’re doing it. It’s them that were suffering. I appreciate there’s bed pressures and that’s a process but actually there’s a real person sat there who could be at home and that we were doing them a disservice.’

CONSULTANT

Case Study B: Mandated buddying at Green Bay

Mandated Buddying at 'Green Bay'

Following a CQC visit in 2013, Green Bay was put into special measures citing issues with its financial control and emergency pathway. As part of its special measures programme, Green Bay was buddied with a different Trust – 'Regency Vale' – selected as an organisation considered to be doing well from a quality or finance perspective.

The partnering response

Green Bay had historically been associated with sub-standard leadership. This was related to a high turnover of executive and non-executives combined with a lack of effective oversight capability regarding information and processes. A range of deep rooted problems regarding quality were also connected to a bad reputation by the local population, special measures status, and a financial deficit. The situation had culminated into a 'treadmill' of stress and feelings of disempowerment. A large hospital dealing with large volumes of patients had compounded feelings of being overwhelmed by the situation.

Recently appointed board members looked to introduce a different leadership style. The approach taken looked to encourage greater engagement of staff as well as 'opening up' the organisation to new ideas and expertise regarding service improvement. Central to this was the introduction of a range of partnering arrangements. This included buddying with other hospital trusts, working with private sector consultants, and non-profit organisations.

The buddying arrangement with Regency Vale was cited as being crucial to the Trust building its capabilities and skills for service improvement. It was supported in large part because it built on existing relationships, as members of the Green Bay board had worked there previously. Framed as something more akin to a mentoring arrangement, the buddying arrangement was a 'loose and very personally defined relationship' based on peer to peer contact between Board members.

'It was a mentoring arrangement I think that's because the Trust we were buddied with, the Chief Executive of the Trust and I worked together in the past so we knew each other very well, and the approach by this Trust wasn't to invite another organisation to take us over or to send in all their troops because that wouldn't help them, they have a job to do as well. It was to test whether the approach we were taking was actually sensible, pragmatic and would stand up to scrutiny.'

CHAIR

These discussions looked to support Green Bay with 'strategic environmental issues', as well as work through any 'Small P and Large P' politics associated with the local health economy. As a peer-to-peer arrangement, there was perceived to be very limited direct impact on the performance (outputs, outcomes) for the Trust. Buddying was more of a sounding board to provide advice as well as test out ideas.

The buddying arrangements were supported by those directly involved. However, questions were raised by those outside of the buddying arrangement about whether the preferred Trust to buddy with was the appropriate fit for the organisation.

Given the number of initiatives that Green Bay was involved in, concerns were expressed about the organisation being involved in too many partnering arrangements. Consultancy firms were engaged and introduced a range 'change management theory' but created confusion as well as questions regarding their sustainability. A preference was made for QI approaches closer to home. Drawing on best practice from within the NHS was cited as a preferred option given its relevance and applicability.

Impact of improvement efforts

The approach taken by the newly appointed board was positively received. Staff reported feeling more valued and engaged in the process. The buddying proved to be vital in supporting the Board in these engagement efforts. Staff involvement in the redesign of the A&E pathway represented a notable case in point. Recent improvements in the NHS Staff Survey results and a CQC report showing 'no more reds' provide evidence of quality improvement in this regard. The greater visibility and stability brought about by the Board was also having a positive impact on staff in allowing for conversations to happen. Improved governance processes were reported with increases in data collection, greater visibility as evidenced by attendance at clinical governance meetings, improved patient flow, and improved financial management. The redesign work carried out in A&E was a notable case in point of these efforts.

Creating a culture hospitable to, and supportive of, change remained an ongoing challenge. Managing expectations in a 'need to see results today' environment remained difficult for the Board. It was likely to take time, focus and effort to embed and sustain the improvement efforts being made. While management-clinical relations were improving, clinical engagement at the frontline continued to be an issue. Work still needed to be done to engage some of the senior clinical communities within the organisation.

Central to the story of Green Bay was also a range of environmental factors cited as key explanations for its current challenging situation. Relationships with national bodies were open and flexible but having 'special measures' status provided an inhibiting factor. Questions were raised about the 'special measures' status and the negative effect it had on the organisation. Challenges were raised about the time and resources being taken to adhere to the reporting and assurance arrangements. The label of special measures was also problematic when trying to recruit and retain staff.

'We were one of the first [trusts placed in special measures] so it really affected our recruitment and retention. People left, people didn't want to come and work here. Especially within the Emergency Department, the reputation went before it.'

SENIOR CLINICIAN

Historically, relationships with the health economy were challenging. A fragmented primary care sector combined with a history of difficult relationships. In an attempt to manage demand, a recently developed urgent care strategy was an attempt to move further into the health economy and manage primary care through advance practitioners. Yet resourcing this change proved to be a continuing challenge. Such resource fragility was evident with the recent Vanguard application as the promised funds for the urgent care scheme were not followed through. Calls for an Accountable Care Organisational type arrangement for suggestion as a next step for Green Bay as a way gain the necessary leadership and accountability to make health economy changes.

Case Study C: ‘Enforced Merger’ between St Phillips and Rowheath Park

St Phillips is a standalone, single site, medium to large size high performing trust. The trust has consistently achieved against regulatory targets for finance, quality, and safety and was rated outstanding by CQC. Rowheath Park was failing and had a very poor reputation. Over recent years, the trust had seen continuous turnover at board level and was described as ‘slowly spiralling into a distressed organisation’. Rated as inadequate by CQC, at the beginning of 2014 Rowheath Park was put into special measures. As polar opposites, CQC saw St Phillips as a solution for dealing with the poor management that Rowheath Park had endured. Following discussion, the St Phillips board agreed to the option of acquiring Rowheath Park. In doing so, St Phillips were given a year to turnaround Rowheath Park.

The partnering response

Following the decision to acquire Rowheath Park, the St Phillips board carried out a range of diagnostic work to better understand the situation at Rowheath Park. St Phillips described how they encountered a range of quality and safety issues related to complaints, serious incidents and a culture characterised by a ‘careless approach’. A decline in performance was evident in all quality indicators, with decreasing referrals, subsequent reductions in income, and poor patient experience survey results also observed.

In response to this situation, the approach taken by the St Phillips board was to focus on culture.

A range of work was carried out on values and behaviours, particularly the translation of St Phillips values and behaviours into Rowheath Park. Staff engagement would also be central to the approach taken in looking to involve and engage staff with a clear vision for change. HR work carried out a range of cultural diagnostic work to find out about the organisation, through staff surveys, turnover, disciplinaries, grievances, friends and family test. They carried out a number of interviews with individuals for Rowheath Park and St Phillips assessing the SWOT for the respective groups. Very clear objectives and milestones were established to ensure progress was being made and the new culture was developed.

HR work to embed St Phillips’ values also included a move to value-based recruitment and value assessment as part of the performance appraisal process. Developing effective operational management through aligning policies, procedures and grading structures also featured, with the implementation of new management structures proving to be challenging and time consuming.

Furthering its approach to culture change, St Phillips developed a new clinical directorate structure with ten clinical chiefs of service with cross site responsibility for services: nine from St Phillips, one from Rowheath Park. These changes to clinical governance looked to provide a more robust governance process as well as improve communication across the directorates.

‘The whole engagement piece was central to everything that we did and above that was an absolute belief that the leadership, the quality of the leadership was going to be the single most influential factor in strengthening the culture.’

HR DIRECTOR

Box 1. Clinical buddying between St Phillips and Rowheath Par

In order to support the acquisition, St Phillips established clinical buddying arrangements where clinical leaders from St Phillips would visit Rowheath Park as a means of practical support for change. Clinical buddying provided intelligence gathering for St Phillips by looking at the clinical pathways within Rowheath Park to identify key issues before take over. The introduction of clinical leaders 'who still knew what good was, or good is' meant that behaviour and practice could be challenged. The buddying arrangement provided an unpressured environment to start to build relationships and understand the service in Rowheath Park, 'the good, the bad and the ugly bit of it'.

The buddying process worked well, and laid the foundations for the new clinical governance structure. However it was seen as a challenging experience for those involved. Clinical buddies described the challenging times of entering the organisation as well as the poor culture they witnessed. Poor clinical management relations were observed with clinicians feeling particularly disempowered.

Impact of Partnering

A range of performance improvements were documented following the acquisition. The change in CQC rating at Rowheath Park from inadequate to good within 12 months symbolised the achievements being made. Furthermore, Rowheath Park met all of NHS Improvement (previously Monitor) quality standards (four hours, cancer standards, 18 weeks, C diff). Rowheath Park achieved a 'totally green dashboard'. Friends and family test, staff survey, were also cited as showing improvements. Feedback from the local community had been very positive, as indicated in the increase in referrals for elected care and maternity services.

Data analytics also documented culture change as measured by value awareness. A year on from being in the bottom 20% of the staff survey, Rowheath Park were now in the top 20%. The most recent staff survey found that 99% of staff were aware of the trust values.

'They came with the attitude that they were superior, and they were going to meet a highly inferior organisation. The reality is that actually it wasn't inferior, it just was inferiorly implemented.'

OPERATIONS LEAD

The experience of leading the acquisition proved to be demanding. St Phillips described the huge emotional labour involved in leading the change. The need to be visible and have face to face conversations with Rowheath Park was very demanding. The pressure to show improvement in preparation for the CQC inspection alongside the day job of managing trust performance led to points of exhaustion. While results documented excellent performance, both Trusts were beginning to struggle, particularly in relation to the emergency department. While RTT still remained over 90%, there were concerns expressed about the financial stability of the current arrangements. Infrastructure issues remained a frustration, with IT being an ongoing issue.

'I don't think buddying works generally because you can only advise, you can't instruct and you can walk away.'

CLINICAL LEAD

‘I think not being bombarded by external organisations is really, really important... you have to demonstrate that level of trust. So, there has to be an understanding that it’s not going to happen overnight. You have to be left alone to get on with it.’

CLINICAL LEAD

Much of the success associated with the acquisition was attributed to the committed leadership of the St Phillips board and its clinical directors. The Board recognised that quality of leadership was going to be the single most influential factor in strengthening the culture. Acquisition success was attributed to the leadership style of the CEO. The open door policy approach of the CE was celebrated. His ability to develop constructive, trusting dialogue set the tone for the executive. The stability of St Phillips was cited as crucial. Described as an ‘unusually tight organisation’ due to the fact many of the consultants and Board had been there a while, a dynamic of team work had developed along with it a credibility and belief that the acquisition would happen and be a success. The experience of working with each other and the trust that had accumulated had created a self-help support network.

The Board looked to combine the carrot and stick approach. They made clear that they were not prepared to tolerate bad behaviour. Signalling that they were prepared to go to dismissal created a shockwave within the organisation that they were serious about changes to be made. A key driver for St Phillips was to gain a larger footprint in the health economy.

Strategically, there had been recognition for at least a decade that they needed to get bigger, either with an acquisition or a merger. In 2013, Rowheath Park appeared on the horizon as the opportunity to develop such a partnering arrangement.

Adequately resourcing the change was also linked to the successful acquisition. The bridging finance from the Department of Health allowed difficult discussions about finance to be kept off the agenda. Furthermore, the additional injection of finance to facilitate the development of new buildings and introduce some new clinical services provided a much needed uplift. St Phillips praised the space given to them by the regulatory authorities to implement the acquisition. The establishment of a Quality Oversight Committee that would get together with St Phillips on a monthly basis provided a helpful sounding board and accountability mechanism to support the acquisition. This included CCGs, NHS England and Monitor as the key external stakeholders.

‘If you’re merging two corporate cultures, which are likely to be quite different, I don’t know how you generate, at speed, a new corporate value, culture ... at least with us it was like, “Fine. We’re coming in, it’s an acquisition. The St Phillips culture, the St Phillips corporate identity, the St Phillips values are going to come to Rowheath Park.”’

MEDICAL DIRECTOR

Poor commissioning was cited as a key driver for the poor performance of Rowheath Park, and the resulting health economy. While Commissioner reactions were indifferent to the acquisition, their initial antagonism was overcome as St Phillips was able to demonstrate a track record of excellence.

Trust was subsequently developed with commissioners giving them the headroom to make changes. The move to STPs had implications as St Phillips were looking to lead the collaboration between the five CCGs they work with. While still uncertain, opportunities were apparent to get a stronger footprint in the health economy. Going forward an Accountable Care model was suggested as a better way of operating.

Reflecting on the acquisition, St Phillips described how this was the most effective partnering approach compared to the other options. Yet the experience was challenging for both parties involved. Building the St Phillips Health identity proved a very difficult task. Criticisms were raised that the dominance of organisational values of St Phillips led to Rowheath Park staff not feeling valued or engaged. Now operating under the name of St Phillips, a sense of loss was apparent for Rowheath Park. Criticisms were also raised by the approach taken by St Phillips as perceptions were created of a 'superior' attitude. St Phillips promoted the language of 'we rather than them and us' to promote a collective experience yet questions were raised about how far the language change was sufficiently implemented. At times Rowheath Park had become framed as bad or even in humour compared to St Phillips.

The acquisition also proved challenging for St Phillips as they were also asked to take on a new identity. The impact on the St Phillips site proved to be challenging as energy and attention went elsewhere. With Board members often at Rowheath Park, developing and nurturing the culture St Phillips development had not kept pace.

Work was now being done to ensure greater visibility and development with the St Phillips site. Sustainability of the acquisition was an issue open to debate. The next six months to a year was crucial to where it's going to go in the future. Changes at board level and how the organisation manages changes were likely to be crucial. The next stage was for St Phillips to grow leaders in the new organisation, something likely to take between five to ten years.

Options for Partnering

A pure merger was not a feasible option as a merger between 'two very different corporate cultures' was unlikely to achieve success. Going down the road of a merger would not have created the possibility to generate, at speed, a new corporate value. Power differentials meant Mergers in their own right were not a good option.

While clinical buddying arrangement was helpful, concerns were raised about buddying in and of itself. As a relationship built on advice, buddying lacked the necessary authority to implement change. A lack of accountability is also a factor as Buddying allowed respective parties to walk away without ownership of the problem. Buddying in and of itself had limited power.

In contrast, an acquisition provided a clear driver for change. Acquisition provided clarity and clear power differentials to push things through, and to just say 'this is how it's going to be'. The arrangement meant that all parties realised that both sides had a vested interest in success (eg, St. Phillips could not walk away if it got difficult).

Case Study D: Voluntary partnering between Southside and Diagnostic UK

Southside is a specialist cancer centre that provides tertiary care on a regional and national basis. Much of its regional services are delivered in local areas through working in collaboration with the local NHS providers. Southside provides its own imaging services within the diagnostic pathway but to help cope with increasing demands contracted with Diagnostic UK. They are a private company that specialises in providing imaging services to the NHS and independent sector hospitals. This includes equipment, associated supplies and radiography and radiology expertise. Initially the partnering was limited to Diagnostic UK providing a mobile scanning service at a local hospital in the region and on Southside's own site. Due to growing demand this was then consolidated to the building of a fixed-modular scanning facility at one of the local hospitals for which Southside provides tertiary care. Most recently they have also successfully partnered on a national tender to improve access and quality of imaging services.

The partnering in practice

At the fixed site Southside receives patient referrals for imaging and justifies if the diagnostic test is appropriate. If this type of imaging is required and the individual lives in the vicinity then Southside will ask for the scan to be completed by Diagnostic UK. Southside is responsible for developing the patient list for each day and this is recorded on their electronic patient management system. This system is used by Diagnostic UK to identify who will be scanned each day and to then communicate the scan to the radiologist in Southside. Diagnostic UK have full responsibility for the running of the scanning facility including maintaining of the equipment, supply of connected materials, and the work of the radiographer and clinical assistant staff. Southside provides medical physicists to ensure that radiation levels are acceptable and that equipment and patient processes are optimised.

A further element is that Diagnostic has developed contractual arrangements with the local Trust on whose site the base is situated to provide cleaning, maintenance and other support facilities.

Through the national tender Diagnostic UK will be building new fixed sites in 30 locations across the country. This will increase the NHS capacity to undertake the imaging procedure and provide the latest equipment. Southside will work with the local sites to consider their diagnostic processes and identify potential opportunities to improve their standards. They will provide training and development for various staff groups connected with the pathway through its own specialist academy. Both partners are also working together to develop a national imaging network that bring together clinicians and others from these local sites. With the clinical governance committee chaired by an independent leading clinician, the collaborative network aims to provide a means to share learning, develop national standards and best practice, and co-ordinate associated research activity.

‘We outlined our vision of research evidence base, the leadership that they could provide, the application of their teaching and educational skills... in the space of three months we arrived at a framework agreement for partnership...’

SENIOR MANAGER, SOUTHSIDE

Impact of partnering

The NHS staff from Southside and the local Trust site identified that the partnering arrangement had provided a significant increase in the imaging capacity of the NHS, reduced the diagnostic timescales, and ensured that the latest equipment was being deployed. The base meant that patients did not have to travel as far too, whilst maintaining central expertise. The fixed site was unanimously seen to provide a more patient friendly environment than the previous mobile units with better waiting facilities and improved access for those with a disability. NHS staff also highlighted the helpful challenge of Diagnostic UK stretching beyond the traditional productivity of the NHS in relation to the number of patients scanned each day. This was making Southside question the boundaries that they had had previously imposed regarding access to such equipment. Diagnostic UK views the new national arrangements as leading the way internationally with opportunity to therefore replicate in other health systems. Formal data regarding the impact of the partnering was limited, at this stage, to activity data such as the number of scans each day and short feedback from patients on their experiences. Much of this was manually collected and there were connectivity issues between the two patient management systems. Going forward the national collaborative network will have much more formal evaluation processes in place.

The partnering did not begin with a national service in mind. Instead the arrangements have emerged over time as the levels of trust grew and opportunities have been presented. Their roles have been flexible in response to these opportunities. Initially it was Southside who funded arrangements regarding the local contract and could be seen therefore as the lead, whereas it is Diagnostic UK that is the lead contract holder for the national work. Beyond these more structural elements, over time good working relationships have been developed between key individuals within the two organisations.

This has considerably helped with implementation of new partnering arrangements. To oversee the national work, formal governance arrangements have been introduced with a series of operational and project groups reporting into a joint board.

Major developments have been instigated and decided by executive management within the two organisations. Both executive teams saw themselves as being entrepreneurs within their sectors and willing to move quickly to take advantage of new opportunities. Beyond the key agreements, responsibility for taking forward the partnering has lain with clinical leads and senior managers. They have been given autonomy to develop and operationalise the overall vision. Within Southside this includes medical clinicians, physicists, training and finance leads. Regular meetings between the key staff within the partners provide opportunity to discuss issues that arise. The executives are also available if necessary to respond to any more challenging questions or barriers.

‘There is a hell of a lot of trust and you get to sticking points and think “yeah well, we’re now grinding a little bit”, so it’s working through those pinch points that I think the team have done really well... One of the things that’s been great is that when we have those pinch points the CEO, COO and the FD sit down at the same table for a whole afternoon and we’ll sort it out.’

CLINICIAN, SOUTHSIDE

There is a shared responsibility for engaging with stakeholders external to the partnership with the appropriate representative taking the lead. So for example clinical staff members in Southside often understand best how to communicate with their counterparts in other NHS organisations. This is particularly important with Diagnostic UK being from the private sector as they have experienced a mixed response in the past from NHS staff.

‘I think the key thing is always the communication... If you can get it so that you’re all singing from the same hymn sheet and you’re all kind of working towards the same thing it’s great.’

MANAGER, DIAGNOSTIC UK

Whilst some have been welcoming of the additional capacity and skills others have seemed resentful of such a service being delivered outside of the public sector. Southside staff members were aware of such views and in some case had some sympathy for the overall logic of the risks of privatisation. However all reported that in their interactions with Diagnostic UK they had experienced similar values with a common commitment to focus on improving patient care. These were seen to enable a cultural fit despite the differences in organisational ownership and governance.

‘It’s always been as equal, I never felt patronised by them. I’ve felt they’ve been very transparent and straight with us and certainly the contracts I mean they’ve been very supportive.’

CLINICIAN, SOUTHSIDE

Case Study E: Voluntary merger between Greenpoint and Middleton Way

Greenpoint and Middleton Way are two small to medium size specialist acute providers operating within a large, diverse metropolitan area. In 2015, Greenpoint and Middleton Way Trusts began a process of collaboration that led to the merger of these organisations.

The merger has been driven by a variety of factors that brought these two trusts together. At the time, Middleton Way was described as in a difficult financial position as the result of a major capital investment project that had failed to come to fruition. The resulting financial loss and instability led to the CE and Chair to step down with some other board members leaving shortly after that. A CQC review of Middleton Way during this time period also identified a number of areas requiring improvement.

The vacancies at Board level at Middleton Way triggered a 'window of opportunity' for the Greenpoint CE to become the joint chief exec across both trusts. Following on, the board at Greenpoint began to get increasingly involved in and aware of the governance issues at Middleton Way. In doing so, these increasing interactions turned into discussions and actions to formally acquire Middleton Way. Running alongside these developments, Greenpoint had for some time been interested in moving into a new '21st century' building. Their preferred location for any new development was to move closer to other acute providers in the area. The most obvious partner out of the acute providers available was Middleton Way given the nature of their clinical services.

'I guess we're about a year down the kind of formal process but in practical terms, we're probably about ten years down the informal journey so long, long before I came... There had been conversations about coming together.'

MEDICAL DIRECTOR

The partnering response

The combination of financial difficulties, the cancelling of an ambitious building project, and the subsequent low morale at Middleton Way created a range of challenges for Greenpoint to resolve. The approach taken by the Greenpoint board was to focus on culture and instil a shared vision of 'we are one trust'. Framing the language and behaviours surrounding the acquisition as a collective effort was central to the Greenpoint approach.

Given the different but complementary specialist services being provided by both trusts, the partnering arrangement would be described as a 'vertical integration' of services. 'Integration' rather than merger or acquisition was the preferred term in recognition of a collective effort to 'work beside you'. The branding produced for the proposed changes describes 'working in partnership'. In contrast with horizontal mergers eg, merging clinical services for financial savings and higher quality service, the proposed partnering arrangement looked to improve existing processes and get both organisations closer together. The merger would build around changes to corporate service functions. They focused on 'the basics' eg, payroll provider, a single kind of ordering system, single telephone system, email system, a single intranet, and complaint and incident reporting process. In doing so, it was predicted that the merger would make a £7 million saving by back office and corporate services coming together. Getting rid of a board was likely to save £1 million. There were savings also to be made clinically with mergers of back office pathology and diagnostic processes.

The development of this partnering arrangement captures how Greenpoint has been required to respond to changing regulatory requirements taking place during this time. Those leading the merger described how the approach taken changed from a standard Trust Development Agency and Competition & Markets Authority transaction criteria to a more fast-track process overseen by NHS Improvement that brought the organisations more quickly together.

Rather than the traditional approach of keeping merging organisations separate until sign-off, the merger took place in a more evolutionary manner. This was exemplified by the 12-month long buddying relationship where the chief exec and chair occupied joint roles with the rest of the executive, and a selection of non-executives, moving into the joint roles four or five months ahead of formal merger. Many corporate areas also merged, running as single teams prior to organisational restructuring. That said, 'formal restructuring' would be delayed until after the merger was completed. This was in recognition of the precarious situation but also in recognition of the need for further financial investment.

The impact of partnering

A range of benefits were anticipated as a result of the merger. With the ultimate goal of the partnering arrangement being to move on to one physical site in the longer term, Greenpoint believed that the achievement of a one site model would provide necessary financial stabilisation, particularly for Middleton Way who were described as financially non-viable. It would also provide a range of clinical benefits as evidenced by other 'world leading' healthcare organisations delivering similar services.

Anticipated workforce benefits were also envisaged, including raising the standards of workforce KPIs such as staff satisfaction, would staff recommend as a place to work, appraisal rates, and mandatory training, and mix of staff. Patient benefits were likely to take longer to assess but it was anticipated that the merger would reduce readmission rates as both organisations worked closer together for particular patient groups requiring both hospital services. The merger was intended to create a new admissions pathway to increase collaboration and improve demand management. Other improvement measures were also being sought.

'The STP process has brought a kind of expectation of I guess a more systematic, more system-wide leadership approach and that's meant that it's been in some ways easier for us to step back and say right, we're going represent the broad views of [the trusts] as a system leader.'

STRATEGY LEAD

Seven quality improvement programmes were being developed for the new merged organisation, drawing on improvement science methods. Benefits were framed in terms of preventing deterioration. This was in recognition that most mergers and acquisitions 'have a dip' in year one as staff go through a period of significant uncertainty.

Benefits were envisaged in light of the current Sustainability and Transformation Plan (STP) agenda. Being a large, combined organisation, was intended to give the merged trust more strength and voice for their respective services. Greenpoint's service area became one of the local STP priority areas. As a result, the trust envisaged greater influence over partners in the health economy. The STP gave them wider opportunities to improve the health of the population, as encapsulated in the commitment that to reduce mortality in the area by 2020.

Given the changes taking place regarding policy and regulation surrounding the merger, in hindsight a lighter version of the Post-Transaction Integration Plan submitted to NHS Improvement would have been better to enable the merger to have more flexibility.

Care was needed in communicating the benefits to staff. There were strong clinical benefits to coming together however concerns were raised about overselling the narrative 'to the point where the credibility is questioned'. Given the financial situation, and that there was no viable alternative ('if you don't do this, we'll be asked to do it or made to do it or someone else will do it or we'll be in a weak position'), work also needed to be done across both organisations to communicate the need for a systems-based view of care. Plans were in place to invest further into OD Leadership and culture development to support these efforts, particularly related to systems and process improvement.

While the merger moved relatively quickly, the journey towards such an arrangement has been on the agenda for some time. Both trusts were 'probably about ten years down the informal journey' of partnering across clinical areas. Explaining the rapid process was also linked to changes at board level. The strong visionary leadership of the Greenpoint CE combined with the arrival of new non-execs who were focussed on making the change happen. The visibility of the executive, particularly the CE, helped to set the tone of commitment and direction. The STP process and the expectation of a more system-wide leadership approach accelerated the application process. The STP agenda reframed the debate to both trusts to step back and represent the broad views of their patients as a system leader. Where previously it would have taken years to develop, the current environment allowed the transaction to be completed within 12 months. As it stood the merger had been agreed subject to governor approval.

Time constraints to push the merger through meant that full discussions and engagement across the organisations was not possible. This was particularly the case for Middleton Way. Those involved described how further engagement and work during the merger would have increased awareness and buy in to the process. The merger was often framed solely in 'transactional' terms at the expense of involving and developing staff.

It proved to be a challenging time for Middleton Way as the takeover led to uncomfortable situations and feeling of inferiority. While it was framed as a two way 'best of both worlds' exchange of best practice, it was Middleton Way who tended to receive new processes from Greenpoint. The levels of ambiguity associated with the merger and anxieties associated with job losses and restructuring could have also been more clearly communicated to staff. However to achieve such visibility and engagement proved to be 'very resource hungry' in taking up senior management time and energy. It was proving very challenging to be 'in two places at once'.

The experience of the Greenpoint – Middleton Way merger also highlights the competing needs and demands of the regulators. While NHSI were increasingly encouraging a fast-track transaction, the underlying processes rested on previous guidance and templates developed by Monitor and the Competition and Markets Authority. These processes were at odds with a fast track approach taking time to complete and difficult to navigate. As a result, the merger was described as being processed 'in spite of the regulatory framework' as Greenpoint 'worked around it'. The negotiation of funding to support the merger also proved to be a challenge. The mixture of capital and revenue for the process and support for the transition phase of the merger meant negotiating with multiple people such as NHS England, CCGs, and NHS Improvement. Gaining the commitment to funding across these groups proved to be a challenge with the allocation only being resolved when escalated to senior NHS positions.

'I think we've gone through the process in spite of the regulatory framework and we kind of worked around it. Not because it's helped us.'

STRATEGY LEAD

How do we successfully partner?

The experiences of the case studies in this research suggest that partnering between NHS providers can be an important enabler for service improvement. It can enable organisations to develop collective offers which provide more integrated and holistic support through building on the expertise and resources with the partners. It can also be an effective contributor to supporting organisations which are experiencing challenges in the quality of their care to understand how to improve and implement the necessary changes. They also highlight that positive impacts are far from guaranteed and developing partnering can be a costly and unhelpful distraction. The environment in which partnering is being undertaken is an important influence through providing support and related resources or alternatively acting as a distraction or enabler.

This complex picture mirrors the views of the NHS stakeholders interviewed at the beginning of the project and highlights the need for a nuanced and informed understanding of the opportunities and implementation of partnership arrangements. In this section we will draw out key learning that can be taken from the research.

No one type of partnering is better

Our case studies reflected different scales (individual – structural) and starting points (voluntary – mandated) of partnering. They suggest that all of these can make a positive contribution to improved quality given the correct opportunities, organisational investment, and environment (see Table 1).

- Individual partnering can provide a cost-effective means to introduce new practices and enable mentoring and reflection for those tasked with leading improvements. It has the potential to drive entrepreneurial activity, injecting innovation and energy to improvement efforts.

- Structural partnering facilitates more fundamental and sustained change across organisations and systems. The formality of agreement enables partners to have the confidence to invest capacity and energy in the arrangements and increase the scale of impact. Partnering can be successful between NHS and private organisations and bring helpful diversity of resources, skills and networks.
- Mandated partnering by regulators can make a positive contribution to the recovery of a struggling organisation. This requires careful assessment of the factors underlying the poor performance, sufficient capacity and relevance of the suggested partner to respond to these factors, and an acceptance from the organisation of concern that such support is necessary.
- Voluntary partnering has the potential to tap into the intrinsic interests of those involved. Through the alignment and interests of those involved, it can increase buy in from within each of the respective organisations. However, care is needed to ensure that there is appropriate co-ordination and governance to ensure that activities are planned, with periodic analysis of impact necessary to ensure that benefits are being realised.

Leading and managing partnering is different

The importance of senior and clinical leaders in the achievement of successful change is well established. This is also true in partnering where leadership entails engagement and influence across organisational and service boundaries. Staff members not only need to have faith in their own leaders but also in those of their partnering organisations. A clear rationale is therefore needed in any partnering arrangement. The qualities of openness, honesty, and critical reflection about the nature of any partnering endeavour are central to positive engagement in the process.

Managing across partners provides additional complexity due to different financial processes, internal accountabilities and underlying cultures. These complexities must be recognised to enable logistical issues to be considered and addressed. For example, our research finds that structural partnering will require a formal infrastructure with support from shared project management capacity. Individual partnering can be undertaken but within an established framework to map out relevant milestones to help ensure that focus is not lost in the demands of clinical work pressure. Testing out potential partners through smaller projects provides an opportunity to explore if the considerable investment in management time will be worthwhile. Rushing in to structural partnering and a pre-subscribed arrangement may lead to a poor fit and considerable diversion of management time.

Individual trust will always be key

Whatever the scale of the partnering there will always be key individuals whose personal collaboration will be key to success. Entering into such arrangements will entail additional risk in relation to resources, reputation and capacity. Successfully managing this risk will involve these key contributors being able to trust that the other partners are sensitive to their requirements and pressures and will not act in self rather than joint interest. Previous positive interaction will provide a foundation to build upon but such relationships will not always be in place. Enablers of trust include the opportunity to progressively build over time through less risky and lower intensity projects, and a good fit between the partners' respective values relating to the partnering endeavour. For example, if they both see benefits for patients as the key consideration and prioritise resources accordingly.

Mandated partnering arrangements that are brokered by an external body may not benefit from the cultural fit that would enable a commonality of approach. In such cases it will therefore be necessary for one partner's culture to be adopted or alternatively the development of a new, shared culture which is likely to be that of the partner perceived to be higher-performing.

Doing so will require considerable and sustained effort across organisation levels which will take years rather than months. In such cases trust will be fostered by transparency in what is being planned and initial agreements being honoured. If such intensity of intervention is not achievable then it is better not to commence with such partnering. Requiring a provider to engage with multiple partners as part of an organisational improvement plan will mean that there are multiple cultures to be understood and responded to which may be an unfeasible expectation at such a time of change

Meaningful data is hard but vital

Relevant, accurate and timely data regarding the impact of partnering is a challenge. Our research finds that structural partnering has to consider a wider range of factors but its scale has some advantages in that aggregated CQC and NHS Staff Survey performance measures may have some relevance. Contractually based arrangements can include targeted data gathering and connected resourcing as part of the contract agreement.

Yet to fully assess impact, partnering data provides practical challenges of accessing data from across multiple providers with different information governance arrangements. In structural partnering a joint performance board which develops the data set, considers related analytics and can then act upon these is essential. In mandated partnering involving regulators on such groups can provide assurance and therefore willingness for light touch during the transition. Given the local contextual arrangements, individual partnering may require customised approaches initially but the capacity cost that this entails should be recognised. Patient perspectives can be invaluable in testing if partnering is leading to improved experience which will motivate clinicians to maintain their commitment.

Environment can make or break partnering

The environment plays a major role in enabling or preventing the partnering arrangement from achieving its potential.

Interest could be helpful if seeking to understand the reality and provide appropriate support, but too simplistic expectations and additional reporting requirements could provide interference and distraction. Those who create such environments through commissioning, policy and regulatory processes must therefore be aware of their influence and use this responsibly. They should also recognise the limitations and costs of partnering and that sometime individual organisational responses may be more appropriate. Reflecting the systemic nature of organisational health, mandated partnering should not purely focus on the organisation of concern but also seek to engage the wider system.

This can provide opportunities for partners to draw on additional resources and help to generate public approval for such arrangements. Quality oversight committees which involve regulators and other national bodies can provide an effective forum enabling relevant connections and giving assurance.

Mandated partnering partnering should be considered with caution and may be best seen as an option that can be offered rather than insisted. If more directive intervention such as organisational integration is deemed necessary, then regulators being clear and honest about these arrangements is crucial for staff and wider stakeholder engagement.

Table 2: Partnering types and impacts

Partnering Arrangement	Main Advantages	Helpful Context	Key enablers
Voluntary – individual	<p>Facilitating clinician-led improvement projects across common pathway</p> <p>Securing support from immediate teams</p> <p>Introducing new practices quickly (although at small scale)</p>	<p>Previous positive working across the services</p> <p>Organisational support for partnering in general and with the suggested partner(s)</p> <p>Identified need or opportunity to improve patient care</p>	<p>Leads within individual services communicate well and share responsibilities</p> <p>Engaging operational managers in both partners</p> <p>Structuring in time for shared reflection on progress</p> <p>Mainstreaming within normal processes and data capture</p>
Mandated – individual	<p>Provides mentoring opportunity to share concerns and discuss potential opportunities</p> <p>Relatively low cost and easy to organise without major organisational disruptions on either side</p>	<p>Organisation seen as requiring improvement recognises needs for change and is looking for support</p> <p>Organisation seen as requiring improvement has resources required to implement changes</p> <p>Individual partnering is linked to wider internal and external change programmes</p>	<p>Individuals in both organisations have sufficient time to meaningfully engage</p> <p>Individuals in both organisations remain connected throughout the process</p> <p>Prioritise and focus on key partnering opportunities rather than introducing multitude at the same time</p>
Mandated – Structural	<p>Enables acquiring organisation to have legitimacy and power to introduce its practices</p> <p>Internal and external stakeholders understand the basis of the relationships</p> <p>Acquiring organisation can shape the new entity to meet its overall strategy</p>	<p>Acquiring organisation is already looking for opportunity to partner</p> <p>Acquiring organisation has strong financial position and stable Board</p> <p>Regulator and commissioner are willing to provide financial support and time for acquisition to be undertaken</p>	<p>Thorough communication to staff and stakeholders of both organisations</p> <p>Seeking relevant data, patient experiences and staff perspectives to assess current position</p> <p>Introducing shared governance and management structures</p> <p>Enabling key stakeholders to have regular updates and contribute insights</p> <p>Recognise strengths within acquired organisation and avoid negative stereotyping</p>
Voluntary – Structural	<p>More formal sharing of resources and risks</p> <p>Partnering provides resources and influence to fulfil individual organisation objectives</p> <p>Opportunity to add value beyond fragmented organisational responses</p>	<p>Organisations are in strong financial positions and have stable Boards</p> <p>Organisations are comfortable with partnering in general</p> <p>Previous positive experiences of working together through smaller scale projects</p> <p>Opportunity to attract new resources to deliver shared project(s)</p>	<p>Dedicating sufficient resources to develop more formal and large scale partnering</p> <p>Key values of organisation are similar in relation to the project(s) in question</p> <p>Opportunity for key individuals within the organisations to directly engage with their counterparts</p> <p>Clear vision of what partnering will achieve with positive support of Board and Executive members</p>

Conclusion

Partnering is at the heart of current reforms in the English NHS. New types of alliances are being explored as a means to better serve populations and ensure that quality continues despite pressurised budgets and demographic changes. They reflect partnering arrangements that have been deployed in other sectors and build on a similar set of assumptions about diversification of offer, sharing of good practice and efficient pooling of resources. This research confirms previous evidence that whilst partnering does have potential benefits these are not easily gained or sustained. It should only be entered into cautiously and within an environment that will at best encourage or at least permit such relationships. An overly optimistic view about the gains to be had, and the resources and timescales required, is naïve at best and neglectful at worst.

Partnering requires a clear focus, an achievable opportunity, and a sustained commitment if it is to have meaningful impact on the quality of care provided.

There is a need for sophisticated understanding about the alternative partnering options and what implementation will entail. Partnering does not have to be a voluntary activity and can be stimulated by competition given the right incentives and circumstances. Whatever its starting point there is a need for clear outcomes, meaningful data, and critical reflection on what is actually being achieved. Policy makers, regulators and commissioners need to ensure that their expectations are realistic and their influence supports not suffocates partnering which shows promising signs. Going forward, we need more opportunities for leaders, managers and clinicians to learn about the practicalities of partnering, and to apply principles of collaborative practice on an inter-organisational basis. We need to grapple with the separate data sets and systems and find ways to generate meaningful insights that can enable honest and action oriented reflection. And we need more research into the actual impact of partnering arrangements and how different options can be implemented and improved in changing contexts.

References

- Ahmed-Little, Y. Holmes, S. and Brown, B. (2011) North West buddy scheme, *BMJ Careers*, vol 14th June.
- Aldwych Partners (2016) *Benefits from mergers: lessons from recent NHS transactions. NHS Improvement*. Available at: https://improvement.nhs.uk/uploads/documents/Mergers_Aldwych_Partners_Overarching_report.pdf (accessed on 16th June 2017).
- CASS Business School (2016) *Mergers in the NHS: lessons learnt and recommendations, NHS Improvement*. Available at: https://improvement.nhs.uk/uploads/documents/Mergers_lessons_learnt_summary.pdf (accessed on 16th June 2017).
- Castner, J. Wu, Y.W. And Dean-Baar, S. (2014) Multi-level model of missed nursing care in the context of hospital merger. *Western Journal of Nursing Research*, 37 (4): 441-461
- Collins, B. (2015) *Foundation trust and NHS trust mergers*. London: Kings Fund.
- Cunningham, I. (2004) *Handbook of Work Based Learning*. Abingdon: Ashgate Publishing Ltd.
- Curtis, B. Gregory, D. Parfrey, P. Kent, G. Jelinski, S. Kraft, S. and Barrett, B. (2005) Quality of medical care during and shortly after acute care restructuring in Newfoundland and Labrador. *Journal of Health Services Research & Policy*, 10 (2): 38-47.
- Dalton, D. (2014). Examining new options and opportunities for providers of NHS care: the Dalton review. London: Department of Health.
- Demers, L. (2013). Mergers and integrated care: the Quebec experience. *International Journal of Integrated Care*, 13(1), 1-4.
- Ehrich, L. Tennent, B. Hansford, C. (2002) A review of mentoring in education: some lessons for nursing. *Contemporary Nurse, A Review of Mentoring in Education: Some Lessons for Nursing. Contemporary Nurse*, 12(3): 253-264
- Field, J. & Peck, E. (2003). Mergers and acquisitions in the private sector: what are the lessons for health and social services?. *Social Policy & Administration*, 37(7), 742-755.
- Fulop, N. Protopsaltis, G. King, A. Allen, P. Hutchings, A. & Normand, C. (2005) Changing organisations: a study of the context and processes of mergers of health care providers in England. *Social Science & Medicine*, 60 (1): 119-130.
- Gaynor, M., Laudicella, M., & Propper, C. (2012). Can governments do it better? Merger mania and hospital outcomes in the English NHS. *Journal of Health Economics*, 31(3), 528-543.
- Kadir, S. Nazir, T. Ahmed-Little, Y. (2010) Meet the management: a local initiative. *British Journal of Healthcare Management*, 16: 533-5.
- Kram, K. E. (1985) *Mentoring at work: Developmental relationships in organizational life*. Glenview, IL: Scott, Foresman.
- NHS England (2014) *Five Year Forward View*, Department of Health: London
- NHS Improvement (2016) *Factors affecting the success of NHS mergers*
- Nigah, N. Davis, A. J. and Hurrell, S. A. (2012) The Impact of Buddying on Psychological Capital and Work Engagement: An Empirical Study of Socialization in the Professional Services Sector. *Thunderbird International Business Review*, 54: 891-905.

- Protopsaltis, G. Fulop, N. King, A. Allen, P. Hutchings, A. Normand, C. and Walters, R. (2003) All pain and no gain? A study of mergers of NHS trusts in London: two year post-merger findings on the drivers of mergers and the processes of merging'. In: Dopson S and Mark A (eds), *Leading Health Care Organisations*. Palgrave
- Ragins, B. R. Cotton, J.L. and Miller, J S. (2000) Marginal mentoring: The effects of type of mentor, quality of relationships and program design on work and career attitudes. *Academy of Management Journal*, 43 (6): 1177-1194
- Roueche, A. Hewitt, J. (2012) 'Wading through treacle': quality improvement lessons from the frontline *BMJ Quality & Safety*, 21: 179-183.
- Russell, J. E. A., & Adams, D. M. (1997). The changing nature of mentoring in organizations: An introduction to the special issue on mentoring in organizations. *Journal of Vocational Behavior*, 51, 1–14.
- Vogt, W.B. and Town, R. (2006) How Has Hospital Consolidation Affected the Price And Quality of Hospital Care?. Research Synthesis Report No. 9, Robert Wood Johnson Foundation, Princeton, New Jersey. Available at: <http://www.rwjf.org/publications/synthesis> (available 22nd June 2017)
- Weil, T. (2010) Hospital Mergers: A Panacea?. *Journal of Health Services Research & Policy*. 15(4): 251-253.
- Williams, N. (2006) Spotlight on... buddy schemes, Personnel Today. From <http://www.personneltoday.com/articles/2006/06/06/35767/spotlight-on.-buddy-schemes.html> (Available 22nd June 2017)



UNIVERSITY OF
BIRMINGHAM

Edgbaston, Birmingham,
B15 2TT, United Kingdom
www.birmingham.ac.uk

Designed and printed by

UNIVERSITY OF
BIRMINGHAM | **creativemedia**