Buddies and mergers: decentring the performance of healthcare provider partnerships

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Networks modes of organising continue to be promoted by policy makers as a lever for improving the performance of healthcare services. The development of inter- organisational partnerships such as public–private partnerships, federations, mergers, and alliances signify these trends with the widespread adoption of joint working arrangements across a range of service areas (Lewis et al 2008; Sullivan and Skelcher 2002; Orr and Vince 2009; Glasby et al 2011). Over recent years particular interest has been given to how partnership working can be better used to improve the performance of the hospitals and community services in the English NHS (NHS England 2018; NHS England 2019a). Recent scandals highlighting poor and deficient care in provider organisations (Francis 2013; Kirkup 2018) have led to regulatory approaches that mandate partnership arrangements such as mergers and acquisitions between underperforming and high performing NHS provider organisations. Running in parallel with these developments have been initiatives designed to promote new partnerships with the aim of better integrating health and social care services (NHS England 2014).

Reflecting on the rise of partnership and collaborative working, Dickinson and Sullivan (2014) locate these trends within the tradition of performance improvement in the public sector. Heavily influenced by the principles of New Public Management, inter-organisational collaboration has tended to centre on techno-bureaucratic approaches to improvement through the use of performance targets and measures narrowly defined by measures of efficiency and effectiveness that ignore the cultural performances of collaboration that are deeply rooted in the meanings, values, norms that reside within a particular organisational and cultural milieu (Dickinson and Sullivan 2014).

Current interest in inter organisational partnership working as a mechanism to stimulate turnaround in failing organisations can also be situated within a broader tradition of public service reforms related to the 'management for excellence': the construction of organisational best practice examples that are translated into prescriptions for high-performing organisations (Jas and Skelcher 2005). Jas and Skelcher (2005) note that while the pursuit of excellence may encourage isomorphic processes and secure legitimacy with key stakeholders, the approach cannot, in isolation, be used to explain

improved performance when other factors associated with the organisation and management of services are taken into consideration. Management of excellence theory presupposes that public-sector organisations can be differentiated in terms of their performance, yet definitions of performance are inevitably multiple, contingent, and dynamic, reflecting a mixture of measurement possibilities and contested discursive constructions (Jas and Skelcher 2005).

The purpose of this chapter is to critically engage with these traditions of public sector improvement with a decentred account of inter organisational partnership working in the performance improvement of NHS providers. Situated within a context of continuous restructuring and 're-disorganisation' of NHS provision (Smith et al 2001; Pollitt 2007; Walshe 2010), partnership working in the NHS is often promoted as a means of achieving performance improvement yet these various collaborative forms often fail to achieve the large scale change anticipated. This is often due to a failure to sufficiently engage the workforce, patients and the public in any improvement efforts (Best et al 2012). By paying particular attention to the situated agency of those charged with making such collaborations work, the chapter moves beyond techno bureaucratic understandings of partnership structures and functions with an interpretive account of how NHS provider partnerships are constructed through the ability of individuals to create meanings in action, particularly how situated agents construct their beliefs about NHS provider partnerships against the background of traditions and often in response to dilemmas or problems (Bevir and Richards 2009). We argue that decentring the performance of NHS provider partnerships has the potential to shed new light on the dynamics of collaborative practice, the role of regulatory hybridity, and the contingent nature of organisational turnaround.

Partnering for Improvement

Interest in partnership working has been on the NHS policy agenda for a number of years. The approach came to particular prominence during the Labour government (1997-2010) in the UK which promoted the policy of working across health and social care boundaries as well as cross agency working (Dickinson and Sullivan 2014; Glasby and Dickinson 2008; Glasby et al 2011). Since 2010 the Coalition and Conservative governments have also promoted partnership working with *The Five Year Forward View* strategy setting out a range of proposals to support 'radical upgrades in prevention and public health' that called for 'better partnerships' and the 'breaking down of barriers between health and social care' (NHS England 2014). The agenda called for new forms of organisation, particularly multi-disciplinary community organisations to enable better integration of primary and secondary

care services. The Dalton Review (DHSC 2014) commissioned by the government to support its Five Year Forward assessed a range of collaborative, contractual, and consolidated models that NHS providers could draw on to improve the quality of care (Figure 1.). These options were intended to avoid 'top down solutions' for local health economies but were encouraged in situations of organisational failure and turnaround by providing 'opportunities for successful organisations to bring their proven leadership, processes and expertise into organisations which are unable to demonstrate clinical and financial viability' (DHSC 2014: 4).

Figure 1. Provider partnerships in the NHS (adapted from Miller and Millar 2017; Dalton 2014)

Partnership type	**Partnership function**
Merger:	Where two or more organisations combine their resources to form a new organisation.
Acquisition:	Where an organisation becomes subsumed by an acquiring organisation
Buddying:	Where individuals or organisations with more experience help, mentor, advise or train others
Federation	Where several organisations come together to collaborate to deliver one or more type of service or back office provision.
Joint Venture	Where two or more organisations pool their sovereignty to create a new legal or contractual entity to manage a particular service
Integrated Care Organisation	An organisation that brings together some or all of the acute, community, primary care, social care and mental health services in a variety of forms
Service Level Chain	Where one organisation provides services for other providers through a contract, a service level agreement or a fee to use the policies and protocols of the first provider.

Emphasis on partnership working has continued with declarations that collaborative options become 'the new norm' (NHS England/NHS Improvement 2016) with the recent NHS 10 year plan promoting service integration and 'genuine partnerships' across healthcare systems (NHS England 2019a). Central to these agendas has been the creation of Sustainability and Transformation Partnerships (STPs) which bring NHS and local government together across defined areas to 'run services in a more coordinated way, to agree system-wide priorities, and to plan collectively how to improve residents' day-to-day health' (NHS England 2019b). The intention is for STPs to become fully integrated care

systems by 2021. Running alongside these developments have been ongoing concerns regarding the quality, safety and financial sustainability of hospitals and community services. The policy response here has seen attempts to enhance collaboration among NHS providers through the development of new models of care (Starling 2017). The launch of Acute Care Collaborative vanguards exemplifies an approach that encourages NHS providers to work together through the creation of hospital groups and networks to achieve the desired improvements in quality and efficiency (NHS England 2018).

Partnerships are also being sought to facilitate the organisational turnaround of NHS providers within broader regulatory frameworks designed to improve the performance of the provider sector. The Single Oversight Framework used by NHS Improvement (figure 2) details the variety of regulatory approaches being implemented to understand how and where providers may benefit from improvement support (NHSI 2017c). The merger and acquisition of NHS providers between failing and high performing NHS providers has been promoted as a notable example of a mandated partnership that has achieved its objectives (CASS/NHSI 2017; Collins 2015). The promotion of buddying, mentoring and direct leadership relationships between executives and clinicians has also been recommended as a way to provide peer support and learning during mandated organisational turnaround efforts (Miller and Millar 2017).

Figure 2. Summary of current regulatory support for performance improvement in NHS Provider organisations

Levels of regulatory support (NHSI 2017)

- Universal support: voluntary tools providers can draw on
- Targeted support: initiatives designed to help providers with specific areas e.g. intensive support teams
- Mandated support: e.g. appointment of an improvement director, agreed a recovery trajectory in partnership with CQC; appointment of one or more partner (or 'buddy') organisations to provide support

Longer term options for those in special measures for quality reasons (CQC/NHSI 2017)

- Service reconfiguration across different services
- Management support or operational franchise agreements
- Transactions in the form of merger or acquisition of organisations to produce quality improvements

These various interventions resonate with established approaches for understanding organisational failure and turnaround. Empirical work has identified a range of symptoms and organisational factors that often describe the process in terms of four or five basic phases: (see Figure 3; Walshe et al 2004; Ravaghi et al 2017; Harvey et al 2014, 2010; Jas and Skelcher 2005; Boyne 2004).

Figure 3. Stages of organisational failure and turnaround (adapted from Walshe et al 2004)

- Decline and crisis: a long and gradual period of performance decline characterised by a progressive loss of business, market position, resources, reputation and external support.
- Triggers for change: the events or circumstances which mean that the decline is recognised and acknowledged by internal and external stakeholders in the organisation, which may be a particular financial, operational or leadership crisis.
- Recovery strategy formulation: the production of a plan to deal with failure which explicitly acknowledges the scale and nature of the problems and sets out strategies or methods for dealing with them.
- Retrenchment and stabilisation: shorter term actions aimed at turnaround often concerned with dealing with operational management problems, finances, preventing further decline, and securing 'quick wins' in performance which will aid survival.
- Return to growth: longer term actions concerned with setting out the new vision for the purpose and objectives of the organisation

Public sector regulatory regimes have sought to implement these approaches through a combination of 'watch dog' compliance and 'guide dog' support and development roles to performance improvement (Jas and Skelcher 2005, 2014). Current interest in NHS provider partnerships to turnaround organisational performance can be located within these regulatory approaches. In the analysis of UK healthcare systems, both Furnival et al (2017) and McDermott et al (2015) document a range of 'new hybrid regulatory models' that are using improvement support interventions such as capacity building and quality improvement initiatives in parallel with deterrence and compliance approaches that are embodied in directives, targets, and sanctions. These authors argue that regulatory hybridity can provide a way to achieve performance improvement in healthcare organisations. However they caution that a delicate balance of approaches is required which pays sufficient attention to engaging local organisations in regulatory changes. McDermott et al (2015) note

the importance of socio-historical contextual factors that both constrain and enable regulatory hybridity, drawing on the view of Reed (2011) that hybridized control systems often represent 'contested terrains' requiring successful coordination and communication of change narratives within 'precarious and contingent' contexts' (Reed 2011: 57 in McDermott et al 2015: 339).

Such understandings of regulatory hybridity are based on the perspectives of those working within regulatory organisations. The perspective of those working in organisations that are responding to regulatory approaches to failure and turnaround have yet to be captured empirically, especially in relation to how local actors negotiate and navigate competing regulatory demands and contexts. Theorising about organisational failure and turnaround has focused on the private sector and has not taken into account the complexity of measuring and improving performance in public organisations (Jas and Skelcher 2005). Furthermore, the often rational-linear theories of turnaround predicting a successful return to growth are in tension with empirical evidence pointing to long term or permanent states of failure for some organisations (Walshe et al 2004). Current mechanisms for partnership working to facilitate turnaround, such as mergers, are often susceptible to building on 'simplistic assumptions' about processes of organisational change that fail to take into account or engage with inter-organisational relationships, capabilities, norms and trust (Fulop et al 2005; Sanderson et al 2018).

New partnerships are likely to be shaped by local historical contexts and narratives that have emerged over time. Such conditions have been well documented when it comes to working across organisational boundaries in health and social care. Success depends on the presence of a number of factors, including the presence of a shared vision; clarity of roles and responsibilities; and appropriate incentives, rewards and accountabilities (Warwick Giles and Checkland 2017; Dickinson and Glasby 2010; Glasby et al 2011). Collaborative working may also encounter a range of barriers based on structural fragmentation of service responsibilities, conflicting professional ideologies, values and interests, as well as perceptions about threats to organisational status, autonomy and fears about being 'taken over' (Glasby et al 2011; Mannion et al 2011; Dickinson and Glasby 2010; Fulop et al 2005).

Case studies of NHS provider partnerships

Recent mergers and acquisitions between under-performing and well-performing healthcare providers have received much attention by healthcare regulators (NHSI 2016). Studies of these show that while financial and clinical quality improvements have been identified, the time, cost, and

complexity associated with turnaround have led to challenging consequences for stakeholders involved (Aldwych Partners 2016; CASS/NHSI 2017; Collins 2015). The creation of 'buddy' hospitals to provide support to struggling organisations and those in special measures appears to have aided organisational turnaround and performance as measured by the CQC performance ratings (CQC 2017). New models of care appear to show promising signs with research suggesting they have stimulated organisational innovation and promoted system-wide collaboration (Naylor and Charles 2018; Starling 2017) Nevertheless, questions remain with regard to the resulting efficiency and effectiveness of these efforts (Georghiou 2019).

Hitherto, research into provider partnerships has been focused primarily on policy maker concerns related to efficiency savings and increasing service effectiveness. A decentred account of NHS provider partnership contexts has yet to be applied (Bevir and Richards 2009; Bevir and Waring 2018). Our research aimed to capture the perspectives of situated agents engaged in partnerships designed to remedy organisational failure and promote turnaround within current NHS policy environment. Between April 2016 and February 2017, qualitative interviews were completed with key individuals within each of following case study sites:

- A voluntary merger through acquisition between Greenpoint and Middleton Way specialist hospitals (n=7)
- A mandated buddying relationship between Green Bay hospital and Regency Vale hospital (n=12)
- A mandated merger through acquisition between St Phillips and Rowheath Park hospitals (n=11)

These were executive directors, senior managers, clinicians and support staff who were identified as 'boundary spanning actors' involved in leading the development of these partnerships (Nicholson and Orr 2016). The interviews encouraged reflections on the 'partnering journey', focusing on what these partnerships mean and how they work with the view to eliciting insights into the experiences of, as well as assessments of opportunities and challenges for the future (Miller and Millar 2017). Data analysis paid particular attention to narratives regarding the formation and development of these partnerships: how boundary spanning actors constructed and understood these formations and the traditions and dilemmas associated with their enactment (Bevir and Waring 2018).

Those involved in NHS provider partnerships described the contexts and methods for identifying and turning around hospital performance. A voluntary merger involving the joining of two organisations, Greenpoint and Middleton Way was described as a culmination of events between the two hospitals

that brought them together. Middleton Way was described as experiencing financial difficulties due to a major capital investment project that had failed to come to fruition. A Care Quality Commission review of Middleton Way during this period also identified a number of areas requiring improvement leading to the CEO and other members of the board to subsequently stepdown. The vacancies at Middleton Way triggered a 'window of opportunity' for the Greenpoint CE to become the joint chief executive across both trusts with Members of the board at Greenpoint following afterwards. Running alongside these developments, Greenpoint had for some time been interested in moving into a new '21st century' building with a preferred location for any new development 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. These increasing interactions turned into discussions and actions to formally acquire Middleton Way.

> *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 to the hospital there had been conversations about [us] coming together*

The mandated merger through acquisition of Rowheath Park by St Phillips was instigated by the Care Quality Commission (CQC) regulator as a way to stimulate turnaround in an organisation that was 'slowly spiralling into a distressed organisation'. St Phillips was defined as a high performing hospital trust by the CQC that consistently achieved against performance targets and was rated 'outstanding' for finance, quality and safety. In contrast, the nearby Rowheath Park was failing against regulatory performance measures rated as 'inadequate' by CQC and given special measures status. This combined with a poor local reputation and continuous turnover at board level over recent years. The St Phillips board agreed to formally acquire Rowheath Park and were given a year to turn the organisation around by CQC. An additional driver for St Phillips to acquire St Phillips was to gain a larger footprint in the health economy. Strategically, there had been recognition that they needed to get bigger, either with an acquisition or a merger:

> *I think 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.*

Following a CQC visit in 2013, Green Bay was put into special measures citing key issues with financial control and problems with its emergency care pathway. Those interviewed described a range of deep rooted problems including a bad local reputation, financial deficit and a 'treadmill' of stress for staff. As part of the special measures programme, Green Bay was buddied with Regency Vale as a way to improve quality and financial performance of the organisation. For Green Bay, buddying with Regency Vale was supported largely because of existing relationships they had with their executive members. Buddying provided much valued advice as well as opportunities to test out ideas. This feeling was reciprocated with Regency Vale who were happy to provide help and support where needed.

> *the Chief Executive of Regency Vale 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. And so apart from mentoring, they helped with networking us into potential candidates to come here.*

Dilemmas in leadership and management

A variety of different leadership styles and approaches were employed to achieve the desired turnaround and improvement At Greenpoint, leadership by the Chief Executive was considered central to making the change happen, with the visibility of the wider executive helping to set the tone of commitment and direction. Committed leadership by the St Phillips board and its clinical directors was also deemed central to the successful acquisition of Rowheath Park. Described as an 'unusually tight organisation' the relatively stable executive and clinical body meant they had established a coherent team with credibility and belief that the acquisition would be a success.

> *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. So, again, we had a very clear objectives and milestones around that area*

> *it's actually the ability of the senior people to have constructive, trusting dialogue with each other. [The Chief Executive] is brilliant on that and he sets the tone for the executive.*

Green Bay appointed board members to introduce a different leadership style that encouraged greater engagement with staff. Central to the approach taken by the board was also 'opening up' the organisation to new ideas and practices regarding how to generate service improvements.

> *An insular culture had developed so one of the key things the board were looking to do was open up the organisation to new ideas, and to going and looking and finding out what's going on elsewhere… there's no doubt that partnerships for organisations who need some mentoring, coaching and showing what good looks like is essential, and I think we got a lot of support from a range of partnerships, as opposed to specifically from the buddying relationship.*

There were different characteristics associated with successfully leading these partnerships. Those involved in leading the partnership arrangements described how developing a corporate vision through the use of collective language to nurture the partnership working process was mentioned. The Greenpoint board for example promoted a shared vision of 'we are one trust', where 'integration' rather than merger or acquisition was the preferred term. Promoting clinical leadership also featured. St Phillips introduced clinical buddying arrangements within Rowheath Park as way to build relationships and gather intelligence about cultures, behaviours and, management relationships. While those leading this buddying described initial reluctance and scepticism to the exercise, clinical buddying was able to create safe spaces for conversations and reflections on current practice.

> *as soon as we took over Rowheath Park … we had to use the language of we rather than them and us, and a sense that we are in this problem as a collective, so your problem is now our problem, and we can't walk away. So unlike buddying, this is a Catholic marriage, it's one way. So we made that really clear, that our futures were now bonded, … So that, I think people realised. So we also had a vision about what we wanted to do.*

Changes to operations management were often tied into these efforts with a range of HR led initiatives introduced to support the implementation. At St Phillips this included 'cultural diagnostic' work to find out about the organisation using staff surveys, turnover rates, disciplinaries, and grievances. Work on translating values and behaviours into Rowheath Park also included changes to the recruitment questions and performance appraisal systems, and a realignment of policies, procedures, grading structures.

we want to pick up all the stones, we learnt a lot about the organisation by doing that kind of forensic look at stuff.

With one of the biggest emergency departments in the country, Green Bay were implementing a new divisional management structure with these various process redesign efforts. The Greenpoint merger would bring together corporate service functions such as the payroll provider, ordering system, communication systems coming together to make efficiency savings.

you look at our transaction, we have got a projected £7million saving by coming together, most of that's back office and corporate… You know, you get rid of one board, you probably save a £1million and so on and so forth. … there's bits of clinical but it's really around the margins so pathology and diagnostics, you know?

While there was much optimism and belief in the approaches being taken, notable limits to these efforts were highlighted. The emotional labour of leading change took its toll:

for the first like six months I was bloody knackered because every time I wanted to interact with somebody I thought, I don't know them, I'll just pop in and see them

The implementation of redesigned management structures was thought to have underestimated the challenge, time and energy required to deliver the required changes, with IT systems and infrastructure remaining the biggest frustration.

I think we misunderstood the complexity of running a three site operation and that still continues to stretch us, so we got two DGHs 20 miles apart and we're trying to run it on an integrated basis so that's a big challenge.

Concerns were also expressed about the ability to fully engage staff in the process of partnership development. Time constraints associated with implementing the merger meant that discussions and engagement across the organisations was not possible.

Maybe there was a bit too much of a focus on the actual mechanics of the transaction and the, you know, the beasts that had to be fed and, you know, getting all of that right and the money sorted and all of that, and not so much on the softer, you know, how are the teams feeling about this? What are the things that people really value that they want to see continue into the new organisation? A bit more around that, I think, would have probably

made people here feel a bit more like they were on the journey as well rather than they were almost just passengers

Leadership efforts to forge a new collective identity proved at times to be contentious as the language and corporate visions of staff engagement were in tension with the apparent dominance of high performing organisational values:

the perception is it's about adopting the Greenpoint way rather than what the CE says, which is you take the best of both and then you bring them together. So, I think, again, maybe because we haven't had those sessions with staff, you know, just to actually say, "Okay, so how are we going to do this in future? What's the combined way of doing it?" There's just been a bit of a, "Well, we're going to start doing it this way". I think staff here have probably felt a little bit put out about that

Points were raised of disconnect in quality improvement work not 'filtering down' to service levels, along with the time and resources being invested into these initiatives were being taken away from elsewhere.

What we do here is we have all different people come in with different theories and we just keep chopping and changing so nobody ever buys into it because you think, well, it's McKinsey's this week, it's GE next week, it's VMI this week, it's KPMG… we know what we're going to do, we've got the change management theory, and then we always do it across the summer, and then we get into winter, the support has gone, the Green Bay have failed again. So it's about sustainability of any help or buddying that we get, in my mind. It's not just about doing it for a short period of time.

Within such a context, questions were raised about whether the partnership arrangements being proposed were appropriate for the organisation:

I think buddying up is good but it's got to be with the right organisation and our staff are very sceptical because of all the help that's come in… you have to think what are we asking our staff to do? We are asking them to work in one of the busiest hospitals in the country, the biggest EDs in the country, and we're asking them to partner with another hospital that's completely different …. It's about the same size but the attractions are completely different. ….

Dilemmas in Performance Measurement

Central to claims about partnership success would be changes in regulatory performance scores and targets as a measure of improvement.

> *I think we will be judged by the regulators against things like KPIs and finance. That's what will happen. But we obviously, just because of the nature of our organisation, I'm not saying they're not important because they're really important but we also want to have some of the other measures like experience of staff, patient experience getting better but then in reality, that's not what we're going to get measured on externally.*

Green Bay attributed improvements in their CQC scores with the changes being introduced within the organisation. The same would be the case for Rowheath Park who a year after acquisition reported a change in CQC measures from 'inadequate' to 'good' with some services identified as 'outstanding'. Rowheath Park now met all quality standards and a year on from being in the bottom 20% of the staff survey, Rowheath Park were now in the top 20% organisations for staff satisfaction.

> *I think it was about three months ago when we had a totally green dashboard, that's never happened at Rowheath Park before.*

With the implementation of the merger still to go through, Greenpoint were predicting benefits with their merger with Middleton Way around the proposed move to one physical site providing financial stabilisation, clinical benefits as evidence by other 'world leading' healthcare organisations delivering similar services, and workforce benefits evidenced in key performance indicators such as staff satisfaction, appraisal rates.

> *the financial ones are relatively easy I think to kind of capture and to measure so pre-transaction, you've got [Middleton Way] that's financially non-viable. They've declared they're a non-viable organisation in their deficit, they can barely afford to pay the staff… what we set out in the business case was essentially a kind of four-year journey of strengthening that financial position. So, that's an easy one. You can measure that; it's quite-obvious, it's quite quantitative.*

Softer intelligence in the form of conversations and feedback from patients and the public was also being used to gauge performance. Feedback from staff feeling more valued and engaged in the process provided a measure of how things were changing. Greenbay pointed to greater 'visibility and presence' of senior clinicians at clinical governance meetings as a measure of improvement.

when I started here the staff in A & E narrated a story that they felt they were the only people that were interested in patients that were coming in off ambulances, and now we've got the whole hospitals, all both hospitals, interested in the importance of making sure the emergency pathway is as quick and as high quality as possible. And that's a massive mindset shift, which I think the staff in A & E feel has been the biggest difference for them.

The voluntary merger between Greenpoint and Middleton Way highlighted the emergent nature of performance measurement within these partnerships. Plans were being put in place to develop a holistic view of performance that was able to bring together and translate the various performance requirements associated with the partnership. To do so required improved triangulation of existing organisational routine data with other forms of HR intelligence gathered as part of the merger.

We're in the process of putting together an OD strategy that will encompass our performance framework, looking at what our organisational vision, goals and our metrics will be. So once we've got that developed we'll be able to then be tracking that over time and looking at, "Okay so how were we performing around particular targets or finance targets or workforce data" and be able to keep tracking that over time. So and we also want to bring in to that some of those cultural measures like our staff engagement levels and our friends and family test and those kind of things.

While these performance improvements would continue to be captured, the sustainability of these efforts was brought into question. There was recognition that most mergers and acquisitions 'have a dip' in the first year, but combined with a context of increasing patient demand for services meant there was likelihood that performance measures would be further breached in the future. Staff readiness for change was questioned with concerns raised about the time to embed and sustain improvement efforts across the workforce.

if I'm really honest, I think we're in the most dangerous bit of it, because this is the point at which we could go one of two ways. We can either carry on pushing forward, and truly generate what everybody wants to come out of it, which is a combined organisation that all works in one way… Or that will all be too difficult, require too much energy, and we'll divert down what is the path of least resistance. Which is we'll end up with two or three different sub-cultures.

Dilemmas in stakeholder relationships

The ability to engage with different stakeholders in and around these partnerships was central to interpretations of partnership success. The relationship with regulators was crucial in this regard. Central to the successful acquisition of Rowheath Park was the additional financial investment, autonomy and governance support for the regulator to implement the acquisition

> *Rowheath Park was an organisation that had no ambition for many, many years, they had no money. And so to actually say, that actually what we want on this site, we're going to bring these clinical services, these are going to be new buildings that you're going to have that was just really one of the most uplifting things for them.*
>
> *I think not being bombarded by external organisations is really, really important… you have to demonstrate that level of trust. …You have to be left alone to get on with it, and they have to understand you might break a few eggs.*

Greenpoint had contrasting experiences of working with the regulatory requirements for merging services. Those leading the merger described confusion and ambiguity as they encountered a number of changes being made to the transaction guidance by NHS Improvement mid-way through their application:.

> *People at the NSHI are slightly schizophrenic really because one end of NSHI is telling us one thing and another end is telling us another... we've been jumping to both tunes and actually that's been incredibly high maintenance in terms of the Chief Exec's time, the CFO's time, the Finance Team's time*

The 'special measures' status awarded to Green Bay by CQC brought with it a number of challenges related to the time and resources taken up to adhere to the reporting and assurance arrangements as well as reputational damaged being inflicted:

> *We were one of the first 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… Being in special measures really affected people coming in.*
>
> *When you're in special measures, the other side of that is that everybody's scrutinising you and you can't get away from it. So there are, I don't know how many, meetings a month where people*

are holding you to account, whether or not you're doing what you should be doing to get out of special measures. And that is hugely time consuming….

Relationships with other organisations in the health economy were often strained and at times fractious. Ongoing tensions were expressed about the lack of engagement and accountability of other organisations in the local health economy:

I don't believe especially for some areas, and this economy included, that there's been enough scrutiny, enough thought into the reasons why you go into special measures because you could stop and say where was the oversight?

We need to understand not just as organisational issues but actually as placed-based issues and infrastructure issues, which will require some way of holding a ring about some of these issues and accountability….

That said, changes in the health economy which placed greater emphasis on systems integration provided opportunities for growth and stability. The arrival of Sustainability and Transformation Partnerships (STPs) provided opportunities to have greater influence over health economy activities. Organisations anticipated greater collaborations and involvement in the delivery of primary and community services

we're trying to use that [STP] scale so everyone benefits. I think that will be a good step forward. We're a big advocate of GP hubs we want them to work.

we had to reassure the staff here that actually a) it's a bigger health economy, you can no longer be a shining star in a sea of failing organisations, it's about, "How do we survive together as a system, not as an organisation?" which – and we've had to take this organisation through that journey really and actually demonstrate that actually we're asking for external funding too for the transaction so that it can be doable and we can do it well.

Discussion

Inter organisational partnerships are being developed in the NHS as a way to improve the performance of provider organisations. Our empirical study explores the experiences of situated agents seeking to create new organisational structures and working practices in response to regulatory demand. We found that actors draw on a range of approaches often rooted in established characteristics of executive leadership for quality improvement (e.g. Millar et al 2013, 2015; Mannion et al 2016). These situated agents were looking to craft and communicate a local narrative of a merged organisational future across the workforce with visibility and staff engagement viewed as central to translating strategy into practice. They were relying on different forms of intelligence often combining harder forms of performance data with softer intelligence gathered from interactions with staff, patients and the public. These leadership practices sat alongside the implementation of human resource management initiatives that were intending to better understand the workforce being acquired, align processes to support the turnaround of poor performance, while also introducing a series of cost saving measures through the rationalisation of 'back office' services.

Much of what was driving these activities was mandated to meet externally imposed performance targets. These situated agents provided insights into the emotional labour involved in meeting these regulatory requirements while seeking to engage organisations in the change process. The implementation of these organisational changes also highlights gaps within the strategies and management practices for achieving regulatory goals. Uncertainty and anxieties were expressed about the supporting infrastructure and sustainability of these partnerships. Working with external stakeholders influenced these efforts, where partnership success was shaped by relationships with regulatory bodies and the potential to work with the local health economy to manage and sustain any performance improvement efforts.

Taken together these findings illustrate the dilemmas of working collaboratively, yet they also highlight the opportunities brought about by situated agency. Engagement with the partnership working agenda was motivated by opportunities for acquiring organisations to expand their power and influence across local health economies. While these partnerships were triggered by regulatory demands, the idea of partnering had been on the agenda for some time. Actors were actively engaging in these partnerships to expand their estate and gain further influence in health economy decision making and priority setting.

In this sense, these findings offer a way for understanding the situated agency of collaboration beyond a commitment to improving quality and financial outcomes. The partnerships acted as both instruments of opportunity as well as a constraint. Rather than proceeding through a series of linear stages from identification failure and the implementation of turnaround, these findings capture the

active influence of corporate governance, management and the wider environment influencing these organisational settings (Walshe et al 2004; Jas and Skelcher 2005), with accounts of performance rooted in different narratives of problems, solutions and proposed outcomes for these partnerships.

These findings capture the difficulties of re-creating regulatory hybridity within single organisations. McDermott et al (2015) note that while having a combination of bottom up and top down approaches to improvement is desirable, this is difficult to achieve as some approaches have the potential to crowd out others (fig 3 adapted from McDermott et al 2015: 340). Our findings suggest that situated agents face ongoing dilemmas working across these approaches. They highlight how situated agents are engaging with top down approaches within these partnerships as displayed in their accounts of fulfilling regulatory performance requirements and the presence of board level leadership promoting culture change. However engaging with bottom up approaches in the form of capacity and resources for change proved to more variable with limited evidence of empowering the workforce to generate local improvements at the time of the research.

Figure 3. Integrative governance model (adapted from McDermott et al 2015: 340)

		National organisation	Local organisation
Approaches to improvement	Top Down	Q1: Ensuring Evidence of provider partnerships engaging in performance and process standards and accountability mechanism (e.g. targets, guidelines, scrutiny, inspection)	Q4: Embedding Evidence of provider partnerships engaging with developing cultures of improvement (e.g. Board policies, clinical governance, support and resourcing, celebrating improvement)
	Bottom up	Q2: Enabling Gaps apparent in capacity building (e.g. Training in improvement methods, change resource, peer networks)	Q3: Empowering Gaps apparent in local improvement efforts (e.g. encouraging bottom up innovation, problem solving, evaluation)

Improvement

These inter organisational partnerships were receptive to boundary spanning actors based on the mandated regulatory requirements combined with the opportunities to expand and sustain services in the local health economy. However these findings highlight gaps in regulatory hybridity, with a lack sufficient resources and collaborative stakeholder relationships to achieve the desired improvements. McDermott et al (2015) note that hybridisation is likely to need time to develop. Indeed, these other domains might well be evident within these organisations or have been introduced subsequently as a process of hybridisation. However these findings suggest there is still work to be done to engage with provider organisations in order to achieve the desired improvements from these partnership efforts.

Conclusion

Inter organisational partnerships can be positioned within broader narratives of organisational failure and turnaround. Our findings highlight the traditions and dilemmas facing those working in the NHS and reveal how situated agents navigate the complex and contradictory narratives calling for quality and service improvement and organisational development in the context of increasing cost constraints and efficiency savings. As interest in healthcare provider partnerships and integration continues to grow, further decentred research is needed to explore these developments. Our research provides a range of insights into the formation of provider partnerships yet further analysis is needed regarding the social embeddedness of partnership working: how situated agents within these provider contexts embed these practices across different organisational actors and contexts.

Partnership working as an approach to organisational performance improvement captures the hybrid nature of regulation that combines watch dog and guide dog roles and functions. Hybridity in this sense provides a valuable perspective to understand how situated agents navigate these contexts. While its normative element has been played down (McDermott et al 2015), further research is required to consider and problematise hybrid regulatory forms and provide critical insights into the performances of partnership working within these arrangements. Partnerships are reflective of network formations in representing technologies of performance measurement, therefore further research is needed to reflect the neoliberal and managerial rationalities underpinning them (Bevir and Waring 2018). Such perspectives are particularly relevant given the predicted £22 billion shortfall in NHS spending by 2020/2021, and continuing calls for efficiency savings and increasing workforce shortages. Such a context is likely to present further dilemmas for those faced with the challenge of integrated and partnership working.

The concept of regulatory capitalism is a useful lens to view regulatory performance. Levi-Faur (2017) introduces regulatory capitalism as way to understand the rise of the regulatory state as the continuing expansion, adaptation and transformation of commodity accumulation via markets as well as the 'patchwork of institutions' that constitute and govern markets, society and state. While current policy discourses around integration and partnership working suggest a move away from market competition in the NHS, regulatory capitalism would suggest that these developments represent the further institutionalisation of markets via regulatory designs shaping incentives and choices for NHS providers. Further research in this area offers the opportunity to explore this concept within NHS settings, decentring the analysis of regulatory systems as a hybrid of different systems (public, private, civil) of control.

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