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Building an initial realist theory of partnering across NHS providers

Abstract

Purpose

The NHS is facing unprecedented financial strain. These significant economic pressures have coincided with concerns regarding the quality and safety of the NHS provider sector. To make the necessary improvements to performance, policy interest has turned to encouraging greater collaboration and partnership working across providers.

Methods

Using a purposive search of academic and grey literature, this narrative review aimed (1) to establish a working typology of partnering arrangements for improvement across NHS providers, and (2) inform the development of a plausible initial rough theory of partnering to inform an ongoing realist synthesis.

Findings

Different types of partnership were characterised by varying degrees of integration and/or organisational change. A review of existing theories of partnering also identified a suitable framework which incorporated elements key to partnerships, such as governance, workforce, leadership, and culture. This informed the creation of an initial rough theory of partnerships, which proposes that partnership 'interventions' are proposed to primarily cause changes in governance, leadership, IT systems, and care model design, which will then go on to affect culture, user engagement, and workforce.

Implications

Further realist evaluation, informed by this review, will aim to uncover configurations of mechanisms, contexts, and outcomes in various partnering arrangements.

Limitations

As is the starting point for building a programme theory, this draws on limited evidence.

Originality

This paper presents a novel theory of partnering and collaborating in healthcare with practical implications for policy makers and practitioners.

Keywords

Collaboration, partnership working, integration, integrated healthcare, NHS, improvement.

Article classification

Literature review.

Introduction

The National Health Service (NHS) in England is facing unprecedented financial strain following a decade of annual real-terms increases of 1.4%, compared to 6.5% over the previous decade (Gershlick *et al.*, 2019). The pressure from national austerity policies, and more recently the covid-19 pandemic, has coincided with ongoing concerns regarding the quality and safety of the care delivered by the NHS provider sector (Francis, 2013). A key policy response to secure both efficiency gains by service providers, and address unwarranted variation in the quality and safety of care, has turned policy attention to encouraging greater collaboration across provider organisations (NHS England, 2014; The Dalton Review, 2014; CQC/NHSI, 2017). At one extreme, acquisitions have been motivated by pro-market incentives (NHS Improvement, 2017b) "where good providers thrive and poor providers can fail" (Department of Health, 2010) and at the other extreme, 'buddying' has been a feature of the NHS 'special measures' regulatory regime where 'better' performing providers are mandated to work alongside 'lower' performing providers to deliver improvement (Foundation Trust Network, 2014; NHS Improvement, 2017a); CQC/NHSI, 2017).

In between these extremes, an emphasis on collaborative, rather than competitive ways of working, has become central to the current NHS policy agenda to address poor performance, which is manifest in a wide range of partnering options outlined in the Dalton Review (table 1) (The Dalton Review, 2014; NHS England, 2019). Yet, such interest and shifting emphases can be identified at different points in time , with a variety of terms and arrangements having been used to describe such initiatives, including integration, collaboration, and partnership working (Glasby, Dickinson and Miller, 2011; Warwick-Giles and Checkland, 2018). Previous research into the experiences of inter-organisational collaboration and partnership working highlights underlying factors and local conditions that may serve to assist (or hamper) joint working arrangements; these include a shared vision; clarity of roles and responsibilities; well calibrated incentives; and clear accountability (Glasby, Dickinson and Miller, 2011; Warwick-Giles and Checkland, 2018). Recent experiences of integrated care initiatives in England provide further insights into the enablers and barriers of effective integrated working, including the importance of appropriate styles of leadership and fostering good relationships with regulators (Billings *et al.*, 2019; Erens *et al.*, 2019). More recent integrated care initiatives, such as Integrated Care Systems being mandated by 2021 across England as a key component of the NHS Long Term Plan, incorporate inter-

sectoral partnerships across health, social care, and general practice boundaries, as well as intra-sectoral, inter-organisational partnerships between providers (NHS England, 2019).

[Table 1 Location]

Despite this evidence and ongoing emphasis on collaborative working, there has been a lack of independent evaluations of such partnership initiatives (Ball *et al.*, 2010; Dickinson and Sullivan, 2014), which have offered limited actionable insights to support integrated care policies (Lewis and Ling, 2019). Accordingly, major gaps in the literature exist in relation to the theoretical and empirical analysis of partnering, and how and why partnering is supposed to achieve its goals (Dickinson and Glasby, 2010; Miller and Millar, 2017). This paper addresses gaps in our understanding by critically reviewing the typologies and frameworks of inter organisational partnering in the NHS in England, as well as expected outcomes and possible motivations for stakeholders,. Together, this comprises an 'initial rough theory' (IRT) of partnering to inform further realist synthesis (NIHR Funding Award, 2019; Wong *et al.*, 2013).

Methods

. A realist synthesis involves identifying and then testing and refining theories that explain how context shapes the mechanisms through which partnering interventions work to produce outcomes. Mechanisms are defined as the "*underlying entities, processes, or [social] structures which operate in particular contexts to generate outcomes of interest*" (Wong *et al.*, 2013). Dalkin *et al. (*2015) go further in disaggregating the concept of a mechanism into its constituent parts: either a resource that the intervention introduces to the environment, or the resulting reasoning that this incurs in the actors of the intervention. Contexts are defined as "*relatively enduring and are what social programs aim to transform (rather than reproduce) by activating various structural, cultural, agential and relational mechanisms to produce various outcomes"* (Pawson and Tilley, 1997, p. 63), and outcomes are the outputs which the interventions or programmes are intended to generate. At the end of a realist synthesis, it is best practice to have produced a set of refined context-mechanism-outcome (CMO) configurations that provide an explanation of how contexts shape mechanisms through which the intervention leads to particular outcomes, and why this is the case (Wong *et al.*, 2013). It is key to understand how interventions work, and why they do or do not given the presence of different contextual factors.

Shearn *et al.* (2017, p. 4) propose that it is necessary to form an IRT to "*become the object of the inquiry and the structure and framework for examining and synthesizing diverse evidence*". Thus, the IRT that is being formulated here constitutes our initial groundwork for a fully encompassing theory that will explain "what is supposed to happen" as well as "why it is supposed to work". A rough initial theory

"may or may not be constructed in realist terms" (Wong *et al.*, 2013).. In the case of partnerships, the intervention can take many forms, have multiple entry-points, and can operate through hundreds or thousands of actors within organisations, encompassing individual and group behavioural dynamics. So, with messy, complex interventions such as 'partnering', the means through which it is expected to work are often ambiguous or too heterogeneous to easily characterise (Greenhalgh, 2009).

In this case, to construct our IRT, policy and organisational documents were reviewed, as well as various 'tacit theories' present in similar topics in the literature (Shearn et al., 2017). A review of grey (policy and organisational strategy documents within the NHS) and academic literature was carried out in November 2019 – Jan 2020 to gain an understanding of existing typologies of partnering, the expected outcomes of partnering, and the 'active ingredients' at work therein. This utilised searching of Google, Google Scholar, and NHS websites in an unstructured but purposive manner typical of a narrative literature review (Green, Johnson and Adams, 2006). For searches of review papers around partnering, papers were included when they were clearly related to inter-organisational collaborations in the public sector. For organisational documents, Google searches were conducted using terms such as "NHS Foundation partnership strategic document" and for other specific partnership types such as 'alliance' (see supplementary file 1 for full list of search terms) and results trawled for strategic organisational documents. These strategic organisational documents involving partnerships (supplemental file 2) were scoured for intended outcomes and these were extracted into a table. Once the included papers were reviewed and an appropriate categorisation was identified, thematic analysis was then performed in a deductive manner to identify appropriate classifications for these outcomes.

Policy documents were identified in a similar fashion with keywords such as "NHS England", "Partnership", "Collaboration", and more, with multiple policymaker organisations (such as NHS Providers, NHS Improvement) searched for. NHS Foundation, NHS England, NHS Providers, and other organisational sites were also trawled for such documents. Once an initial draft of this paper and theory was developed, it was presented to and deliberated by a panel of eleven experts from a range of organisations with an interest in partnering policies including NHS improvement, the Good Governance Institute, The Health Foundation, and NHS Providers, for review and refinement of its theoretical content, during the course of a 2-hour workshop.

Findings

Phase 1: Underlying concepts

The initial stage of analysis identified a range of underlying concepts put forward by noted scholars in the field (e.g. Glasby et al 2011; Dickinson and Sullivan 2014; Dickinson and Glasby 2010) regarding the

role of collaboration and partnership working across public services, and particularly in health and social care settings. Analysis at this stage also reviewed policy and organisational viewpoints (e.g. CQC/NHSI 2017) regarding the experiences and outcomes expected at both a policy and organisational levels. These outcomes and commonalities were incorporated into the IRT.

Typologies

Reflecting on the various attempts to encourage inter-organisational partnership working in the NHS, Elston (2013: 527) builds on others (e.g. Audit Commission, 1998) to define partnership working as "*a mutually beneficial process by which stakeholders or organizations work together towards a common goal" which "involves the joint development of structures in which decisions are made, resources shared, and mutual authority and accountability exercised*". Miller and Millar (2017) suggest that partnering can also be used as a useful term to understand inter-organisational collaborations. Crowley and Karim (1995: 36) define partnering as:

> *"A co-operative strategy [that two or more organisations implement] by modifying and supplementing the traditional boundaries that separate organizations in a competitive climate. In this way, partnering can be used to create a cohesive atmosphere [in which] all project team members openly interact and perform*".

In building the IRT, we found that partnering types have been characterised using a variety of typologies. One example is the Dalton Review (2014), which distinguishes between different inter-organisational forms, including collaborative (a voluntary pooling of resources which involve two parties creating a third to provide a particular service to both initiators), contractual (more formalised agreements) and consolidatory (a change of ownership, encompassing mergers and acquisitions) forms. The King's Fund (2014) use a continuum to further develop these ideas in terms of the "level of organisational change", with different organisational types associated with different accountability arrangements (fig. 1).

[Figure 1 Location]

Another example comes from the Nsorthern Ireland Audit Office (2019) who arrange different partnering arrangements by their degree of integration, with networks characterised by low commitment at the bottom of the spectrum, through cooperation, coordination, and collaboration, to fully-fledged partnerships which require formal agreements and detailed joint planning (fig. 2).

[Figure 2 Location]

Miller and Millar (2017) incorporate a two-dimensional scale to map out partnering arrangements in the NHS (fig. 3). Rather than the level of integration alone, this typology incorporates two continua: the

degree of intrinsic vs. extrinsic desire to collaborate between participating organisations, as well as the proportion of organisations involved in integration (individual vs. structural).

[Figure 3 Location]

Across these various typologies, our IRT identifies that the degree of inter-organisational integration is a consistent commonality by which it is possible to characterise different partnering arrangements. Furthermore, we posit that the degree of integration is a key element which shapes the mechanisms through which partnering works. While the present analysis is based on UK-based research, this continuum of inter-organisational integration has been proposed by other international models such as in the Rainbow Model of Integration (Valentijn *et al.*, 2013). While Miller & Millar (2017) incorporate whether a collaboration is voluntary or not as an element of the continuum, this circumstance may, from a realist perspective, serve as a contextual factor affecting implementation of partnership mechanisms, rather than a means of categorising them (Miller and Millar, 2017). However, this will be explored further in the next phase of this project.

Outcomes

Intended Outcomes

Here we characterise the various outcomes that organisations and policymakers expect from partnering arrangements. Evidence from NHS reports, such as the The Dalton Review (2014) and NHS Five Year Forward View (NHS, 2014), depict different partnering arrangements as providing a range of potential benefits to population health - improving care, quality, and efficiency. A review of NHS provider acquisitions by NHS Improvement (2017b) found that merged organisations have the potential to help the local health economy by standardising care quality, increasing market share in clinical services, improving financial sustainability, avoiding market share erosion, and improving reputation to aid in staff recruitment (see also Aldwych Partners, 2015). Notably, the outcomes that are expected from partnerships are not always the same as reasons for entering the partnership in the first place.

We reviewed strategic plans from 26 organisations (supplementary file 2) which set out the aims for various partnering arrangements in the NHS. One benchmark example is the five-year strategy for the Guy's and St Thomas' Healthcare Alliance (2017), which outlines its aims and how it intends to achieve them in a very clear manner (fig. 4).

[Figure 4 Location]

Their intended outcomes are arranged into four broad categories: "*delivering consistent high-quality care*", "*developing our people*", "*leveraging scarce resources*", and "*embracing innovation*" (Guy's and St Thomas' Healthcare Alliance, 2017, p. 6). Within these larger categories, long-term and multiple medium-term objectives are presented. For example, within delivering consistent high-quality care, an

objective is to "*provide members (i.e. clinicians) with access to world-leading specialists from within the Healthcare Alliance*", by "*enabling clinician-to-clinician relationships, facilitating knowledge share and access to specialist opinion*" (Guy's and St Thomas' Healthcare Alliance, 2017, p. 8). As a further example (one of many), The West Suffolk Alliance (2018, p. 11) has published a strategy document for 2018-2023, which aims to "*strengthen support for people to stay well and manage their wellbeing and health in their communities*", "*focus with individuals on their needs and goals*", "*change the way we work together and how services are configured*", and "m*ake effective use of resources*".

Based on our review of the 26 documents outlined in supplemental file 2, all intended outcomes reviewed were found to broadly fit within the categories proposed by Guy's and St Thomas' Healthcare Alliance (GST) - that is, quality of care, workforce, resources, and innovation. It is also clear that there is generally overlap between policymaker objectives and those of organisations. However, assessment of these documents also reveals a number of gaps in understanding – particularly whether intended outcomes are applicable to all partnering arrangements or particular types, and whether these outcomes are applicable to particular individuals and groups involved in the partnering process. Further research is therefore needed to tease out which types of partnering arrangements are associated with which types of outcomes and why. These categories of intended outcomes are incorporated into the IRT in figure 6.

Phase 2: Identifying frameworks and propositions

In this section, the aim is to identify existing frameworks of partnering to inform the IPT. By integrating multiple frameworks, a broader perspective of how partnering and integration efforts are intended to work within a UK NHS context can be set out. As Wong et al. (2013) note , there is no definitive guide to this process, so due to the heterogeneous nature of the 'partnering' concept and the absence of existing well-defined programme theories, the search was instead widened to include theories of integration as a whole.

There is a growing body of literature related to classifying partnering types, however, for our purposes, a general model of partnering in the NHS is needed to better understand both 'what' elements are essential to partnerships working and 'why' such approaches might work across in some contexts but not others. Several frameworks were reviewed, and the Assessment tool developed by the Advancing Quality Alliance (2014) (AQuA) was identified to incorporate many of the elements which require integration across partnering arrangements (Advancing Quality Alliance, 2014). This framework was originally developed to rate the implementation of specific elements (in Integrated Care Systems) across the following eight factors: leadership, governance, culture, service user and carer engagement, financial and contractual mechanisms, information and IT, workforce, and service and care model

design (fig. 5). It is through the combination of these various elements that the AQuA proposes that improvements are made in relation to safety, experience, effectiveness, population health, and use of resources. We propose that these factors may also require integration to various degrees in horizontal partnerships in the NHS, depending on the type and the level of integration that would be required, from limited (buddying) to total (merger/acquisition) interaction between organisations.

[Figure 5 Location]

For the purposes of this review the AQuA framework was adopted to provide a series of plausible theories how partnering can be achieved. The review also adopted the categories of outcomes from the GST partnership strategic aims (Advancing Quality Alliance, 2014; Guy's and St Thomas' Healthcare Alliance, 2017). These combinations are depicted in figure 6 which highlights how a partnering intervention may require integration across the domains outlined in the AQuA framework, with a variety of contextual factors with the potential to 'shape' success of any partnership. Some of these contextual factors have been identified in the literature. For example, a review by the Foundation Trust Network (2014) identifies factors which contribute to successful buddying, and includes constructive relationships based on trust and respect (identified as most important); cultural fit; the role of geography (where shorter distances are better), clarity of expectation(s), and organisational capacity. Likewise, a report "Learning from improvement" from NHS Improvement (2017a) looked at partnerships for turnaround and emphasised the importance of choosing the right partner, including the location and resources for the arrangement. Similarly, a recent systematic review of factors affecting hospital mergers emphasised the role of hospital staff being actively included in merger processes by senior management (Keane and Farragher, 2016).

The Advancing Quality Alliance (2014) also forward a number of propositions regarding how integration is supposed to work. For example, this suggests that to achieve cultural integration involves a mutual agreement to work together, an equal commitment to the creation of common goals and cultural change, and development of shared values and vision by staff across organisations (see Table 2 for further propositions). The AQuA framework has been incorporated as a base of our IRT by outlining the domains, such as leadership, culture, and workforce that will be explored in further depth in the next phase of this realist synthesis.

Phase 3: Connecting propositions and domains

The final stage of developing the IRT was to develop the relationships between the various elements and structures identified above. In Table 2, propositions in this theory are put forward, drawing on the Advancing Quality Alliance (2014) and supplemented with other emerging evidence from the review (e.g. Cartwright and Cooper, 1993; Huxham, 2003; IAP, 2007; Dickinson and Glasby, 2010; Northern

Ireland Audit Office, 2019). These factors will be explored further for their relationships to outcomes and mechanisms in an upcoming work, using this IRT as a basis.

In figure 6, the theory is presented as a series of relationships. It begins with the various entry-points or motivations for partnership working which have been identified in the literature (Dickinson and Glasby, 2010). Next, it was identified that partnering typologies can be characterised primarily along a continuum, whereby greater degrees of partnering require a greater level of integration, organisational change, time, contractual obligations, and resources to implement. Buddying would be the lowest form of partnering, whereas an acquisition or merger would be at the highest end (figure 6). This is in line with the characterisation of these partnerships by degree of organisational change put forward in the Dalton Review (2014).

Similarly, if failure is to be avoided, it is suggested that a partnership of a higher level of integration leads to a greater need to consider the role of contextual factors in relation to partnering mechanisms. This is because, for example, as the level of integration, increases, the number of potential points of complexity-related failure also increases, and more turmoil may occur temporarily during implementation. This is integrated as the y-axis of integration/complexity visible in figure 6. Lastly, various 'end states are included for partnering arrangements that may arise: namely, improved outcomes (i.e. successful partnership), maintenance of the status quo – or partnering for no benefit nor detriment, and 'failure', whereby the partnership is a wasted effort that produces worse outcomes in the long-term.

[Figure 6 Location]

While the emerging programme theory of partnering depicts a range of steps between inputs and outcomes, it suggests that rather than linear stages from planning, through implementation, to post-implementation, in practice the partnering process may be a more fluid than this sequential structure - e.g. the planning of aspects of the long-term integration may continue into the initial implementation phase. These temporal and procedural aspects of the partnering process will be explored by the authors in further research.

[Table 2 Location]

This examination of organisational perspectives and theories surrounding the integration of these elements leads to the understanding that different partnering types are likely to interact with some elements more than others (fig. 6). For example, partnership synergy theory suggests that certain characteristics are intrinsic to partnerships, namely leadership, administration and management, governance, and efficiency; and these elements are similar to the domains of financial and contractual mechanisms, leadership and governance, and service and care model design from the framework herein (Lasker, Weiss and Miller, 2001). As such, one could argue that partnering interventions largely exert their forces of change through changes to service and care model design, leadership, governance, and financial and contractual mechanisms, and that subsequent changes to IT systems, culture, and workforce occur as knock-on effects. This supposition of partnership synergy theory has been integrated into our initial rough theory (fig. 6).

Now that the important entry points, organisational domains, outcomes, and potential interactions in partnering are established in our rough theory, the next aim is to explore what exists 'within the arrows' and 'outside the box' (fig. 6), i.e. what contextual factors shape the relationships between these factors, and whether the 'theories' presented in Table 2 are evidenced in practice. This emerging analysis also considers an important role for capability, trust, respect, resource, the role of geography, accountability, and the 'entry point' into the partnership (i.e. is it enforced or voluntary, or is it out of a desire to compete, or to truly collaborate) as contextual factors. An example application of the theory to a buddying arrangement would illustrate that, since buddying has relatively little integration, the complexity of the integration process would be significantly less in comparison to a full merger. The entry point for buddying is typically failure/mandated turnaround, and this mandated nature would imply that additional time and energy will be needed for building and maintaining inter-personal relationships that might well be taken for granted within voluntary partnerships (table 2). Finally, the relationships in the model indicate that it is especially important to consider the role of service and care model design, governance/accountability, leadership, and financial and contractual mechanisms, as primary elements that will be altered as a result of the partnership. For those involved in or wishing to

engage in partnership working, these findings emphasise the importance of careful implementation and consideration of these issues in order to avoid any unintended or dysfunctional knock-on effects on elements such as organisational culture.

This paper is the first step in an ongoing realist synthesis. To enrich this initial theory with further testable elements, the next phase of this project will draw on further literature to formulate explicit, testable CMO configurations. The final phase will incorporate qualitative realist interviews with policymakers and organisational staff involved in a spectrum of partnership arrangements, which will outline differences between partnering arrangements, and will provide a finalised, refined theory of how partnering in the NHS works, why it works, and whom it benefits. The initial theory is therefore intended to lay the foundations for enhanced understanding of the partnership process, and with further realist research will serve to support policy makers and practitioners in the implementation of integrated care initiatives and other inter-organisational collaborations aiming to improve the quality and coordination of care.

Conclusion

This paper establishes a rough initial theory of partnering across NHS providers for application in a realist synthesis. Given the tight timelines for the project, the development of an IRT might well have overlooked relevant literature that could have informed this theory. In response, to improve validation and verification this IRT was presented to an expert review panel where our initial theories were revised into the current form. In line with the realist approach, it is anticipated that the theory will become more robust as primary data is collected and further case studies are incorporated.

The present review sought to establish a working typology of partnering arrangements for improvement in the NHS and has informed the development and presentation of a plausible IPT of partnering in healthcare. Further realist synthesis informed by this review will aim to investigate the contextual factors and mechanisms underlying these elements, such as the roles of organisational capability, trust, and respect. This will provide a clearer picture of how, when, and why partnering and other integration efforts work, and whom they benefit. With significant emphasis on integrated care arrangements requiring significant collaboration in the UK and elsewhere, this work will inform how future collaborative efforts can be better designed for success and provide actionable recommendations for use by practitioners and evaluators.

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Author contributions

XX and XX wrote the initial drafts of the manuscript and developed the theory. XXXXXX and XX provided expertise and feedback on the initial drafts of the manuscript. All authors approved the final version of the paper.

Conflict of interest

The authors declare that they have no conflicts of interest.

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