Provider chains: lessons from other sectors

A report for the Dalton review into new options for providers of NHS care

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Acknowledgements

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Summary

The Department of Health commissioned the Nuffield Trust to review practice in sectors outside the NHS, along with historic NHS experience, to see what lessons could be learned when applying multi-site operating approaches within the English NHS.

The Department of Health has asked us to distil learning from organisations operating chains outside the NHS. Therefore, this report does not seek to make a specific recommendation about whether or not chain-style operating approaches should be adopted by the NHS.

Operating a successful multi-site organisation requires different systems and management approaches from those deployed within a single site organisation. This paper distils learning from interviews with senior leaders of multi-site organisations in sectors outside the NHS to produce a set of lessons for the NHS about what makes a successful chain.

These lessons are then tested with NHS leaders to establish the degree to which they are relevant in an NHS context and to explore how NHS organisations might be best supported if wishing to embark upon setting up or joining an NHS provider chain.

Key Points

- Operating across multiple sites requires a shift to a management system with a corporate centre and outposts, rather than appending an acquired institution onto an existing organisation.
- The corporate centre will have different objectives from individual business 'units' and delivering these will require different skills.
- There is generally a clear distinction between a set of tasks that are to be done centrally and a different set of tasks where individual operating units are allowed discretion, but there a number of areas where this distinction is subject to debate.
- The role of the operating manager at each operating unit is seen to be crucial to the success of the chain.
- Running an effective multi-site organisation requires extensive formalisation and standardisation of operating procedures, management systems and functions.

- Effective multi-site organisations usually deploy significant effort in 'talent management', management development and organisational development.

- Effective chains have clear processes in place for internal quality audit, in order to ensure compliance with governance requirements.

- Successful chains have clearly defined processes for capturing, testing and dispersing innovative practice.

- There is a high level of risk associated with transactions to add operating units. This requires a very substantial investment in due diligence and to integrate units. Caution is required about any policy which reduces the incentives to assess risks correctly.

1. Introduction

Structural change within the NHS provider sector has to date largely taken place as a result of mergers and acquisitions. These have occurred for a variety of reasons. In some instances, trusts have joined together because leaders have seen a case for consolidation. In others, consolidation has occurred as a result of national policy mandates such as Transforming Community Services, or via brokerage arrangements led until recently by regional authorities. New organisations formed as a result of these transactions have often tended to operate fairly traditional organisational structures, even where there is an element of working across multiple sites.

The results of these consolidations have generally been underwhelming. Protopsaltis et al's (2003) analysis of mergers of NHS trusts in London two years in found that "although certain gains can be achieved from full organisational merger, this is not achieved without a number of drawbacks and unintended negative consequences that are often overlooked or underestimated by both policy-makers and managers in the early stages of a merger".

Fulop et al's (2002) analysis of "stated drivers" and "unstated drivers" of mergers, also in a series of consolidations in London, found that unstated drivers could sometimes conflict with stated drivers, bringing about unintended consequences, which needed to be understood. Realistic objectives were required for these reorganisations. Stated drivers, derived from public consultation documents, included the need for management cost savings, to guarantee service developments and ensure quality maintenance. Unstated drivers, as reported by key stakeholders in interviews, included a perceived need to impose new management regimes on trusts deemed to be 'undermanaged', to negotiate deficit reductions and to respond to lobbying from central government, influential institutions and pressure groups. More recent econometric research by Gaynor et al (2012) found similarly disappointing results. This may be connected to a lack of due diligence in many merger decisions and underinvestment in pre-integration planning and post merger organisational development identified in a survey of this area by KPMG (2011).

The objective of Sir David Dalton's review into new options for providers of NHS care is to enable the best NHS providers to offer services to more patients, while helping all providers of NHS care to improve quality. Underpinning this objective is an assumption that some NHS providers will therefore need to make their services available to a wider population using different organisational models from those currently in use, and probably operating across multiple sites. This analysis therefore focuses on lessons that organisations operating across multiple sites can offer NHS providers seeking to disperse high quality operating practice more widely, whilst avoiding some of the pitfalls that previous attempts at structural change in the NHS have exposed.

2. Methodology

The Nuffield Trust conducted desk based research into multi-site working, guided by academic experts in the field, followed by interviews testing how approaches deployed by those in sectors outside the NHS compare with more traditional approaches to merger, acquisition and reconfiguration in terms of operational effectiveness, stakeholder attitudes and the ease of putting such arrangements in place.

We have also explored potential trade-offs, for example between standardisation, control and innovation. A further area for exploration has been the challenges faced by organisations integrating

existing units into their model, when compared with organisations rolling out their model in new locations.

Desk based research

We have conducted a review of published papers, grey literature and other articles relating to multi-site working. In framing and scoping the desk based research for this project, we have taken advice from Birmingham City University Business School's Academy of Multi-unit Leadership. Our research has encompassed published literature relating to multi-site management, managing at distance, understanding the roles of different key players within a multi-site organisation and principles of leadership and followership relating to multi-site operation.

Interviewee/case study selection

i) Non-NHS interviewees
We have sought to take a broad approach, including a diverse range of organisations in our research and encompassing some industries that would not normally be viewed as having close parallels with the health service. This has enabled us to establish which traits of multi-site organisations are widespread, regardless of the sector in which the business operates. Our hypothesis is that these traits will therefore also be relevant within an NHS context.

We have however restricted our search in order to ensure that the chains we studied are operating in relatively complex environments. We selected organisations that were subject to a regulatory regime, were operating in a complex business area with multiple service lines, had a highly professionalised workforce or were operating in the public sector. We included some private sector providers of health services on the basis that these met several of the described criteria and their experiences would be highly relevant. Organisations have therefore been identified for inclusion in the research on the basis that the intelligence generated will be derived from both shared and contrasting experiences.

We selected individual organisations because they meet one or more of the following criteria:

- Businesses operating in a sector that is subject to a regulatory regime
- Businesses employing a highly professionalised workforce
- Businesses with experience of providing health services but that are not NHS organisations
- Businesses operating in a complex work area
- Businesses operating public-facing units (rather than providing services to other businesses)
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Interviews have been conducted with 11 individuals occupying very senior posts across a range of organisations spanning the following sectors, identified with support from Birmingham City University Business School's Academy of Multi-unit Leadership:

- UK-based private health provider
- Pub and restaurant sector
- Casino and gaming sector
- Academy schools sector
- Ofsted-registered nursery provision
- Legal sector
- Large overseas hospital chain operator
- Provider of secure services

Interviewees also drew on previous career experience of running hotel chains, manufacturing and logistics organisations. We found that the majority of organisations working in chain-style arrangements were operating in the private sector. However, we have sought also to use public sector examples where these exist.

The table below shows how the individual sectors relate to the areas of focus we identified:

Table 1: interviewees by sector and area of focus					
Sector	Subject to regulatory regime	Highly professionalised workforce	Providing non-NHS health services	Complex business area	Public-facing units
UK-based private health	✓	✓	✓	✓	✓
Overseas hospital chain	✓	✓	✓	✓	✓
Legal	✓	✓		✓	✓
Academy schools	✓	✓		✓	✓
Secure services	✓			✓	✓
Ofsted-registered nursery	✓				✓
Pub and restaurant	✓				✓
Casino and gaming	✓				✓

In addition to the schedule of interviews, a number of interviewees attended a private round table discussion at the Nuffield Trust offices on 23 July, where emerging themes from the interviews were expanded and prioritised.

ii) NHS interviewees
In order to ensure that the findings from this first phase of research were relevant in an NHS context, we tested the findings with senior leaders at five NHS organisations, selected because we considered that the approach set out in the Dalton review was likely to be of interest to them.

The five NHS leaders worked at NHS organisations sharing one or more of the following characteristics:

- Organisations where a consolidation has taken place
- Organisations where a future consolidation may take place
- Organisations that are 'buddying' other providers
- Organisations that are being 'buddied' by other providers
- Organisations that are subject to performance measures

In each interview, we asked the interviewee about their relevant experiences, described our initial findings and asked for their reflections. We also asked interviewees how findings might be best presented in order to enable them to be used on a practical level by NHS organisations.

3. Findings

Main characteristics of successful chains

Within a chain, individual operating units will be expected to have a significant degree of autonomy. Many functions will remain devolved to individual operating unit level, but the chain structure provides opportunities to streamline certain functions where there are clear economies of scale. All operating units will share a similar status – there will not be a sense of a 'parent' provider unit overseeing the activity of a subsidiary. Overarching management units will perform different functions from units involved in the delivery of the service. These principles are explored in more detail below.

Interviews with senior leaders working in multi-site organisations across a range of sectors and desk-based research yielded many recurring themes. We have distilled these into 10 main lessons from managing successful chains, which are set out below.

1. Operating across multiple sites requires a shift to a management system with a corporate centre and outposts, rather than appending an acquired institution onto an existing organisation.

All multi-site providers interviewed have operated a single management system that is rigorously applied. Some organisations distinguish between a central head office and local operating units, whereas others – usually the larger organisations – incorporate an additional regional management tier, often with a relatively large span of control to avoid undermining the autonomy of the operating units. Management systems generally have very clearly specified decision rights at each level of the organisational structure. There appears to be a strong presumption in favour of a high level of devolved responsibility, albeit within parameters and in line with the values of the organisation and its overall objectives.

Interviewees told us that as soon as two or more operating units are connected in a network, there is a need to look above the individual unit and establish a 'networked' view of leadership and delivery.

2. The corporate centre will have different objectives from individual business 'units' and delivering these will require different skills.

The task of leading across multiple sites appears to be very different from that of operating a single site. Interviewees spoke of according greater significance to functions such as procurement that have traditionally been given less priority in the NHS (see below). Strategic human resources management and organisational culture also become critical at this level. Chief executives moving from single to multi-site approaches have had to disengage themselves from the unit they had originally been running, appoint a person to assume their previous duties, and shift their focus to viewing all sites equally and ensuring a shared set of principles and philosophies underpins the activities of what can be quite a diverse group of operating units

One chief executive operating in the academy schools sector told us: "I had very able deputies in the school I was in. I became CEO [of the chain]. My job was not to be as involved operationally in a place that was judged outstanding. That allowed me to become more operationally involved in the other two."

Another interviewee, in the private healthcare sector, said: "Every one of our hospitals has a dual leadership structure, with a clinical chair chairing an executive board, and a general manager who is

the accountable officer. Those individuals all sit on my executive team… In our analogy, they row in two boats."

This finding is supported in general by the literature on multi-site management. Umbreit and Smith (1990) find that managers in multi-unit enterprises "move from a technical focus in single-unit management to a professional business emphasis in multi-unit management… Successful multi-unit managers establish a high priority on developing strong subordinates, providing a supporting work environment, allowing unit managers to set their own goals and instilling a sense of pride and teamwork…Multi-unit managers… receive great satisfaction in seeing their managers promoted and being part of a winning team. It appears that this value system contributes to their success."

Mone and Umbreit (1989) surveyed multi-site managers to identify which of five criteria had posed them most difficulty when making the shift to multi-site management. They found that human resources management played "an increasingly significant role in the day to day activities of the multi-unit manager", particularly when the multi-unit manager was making the transition from single unit management. The skills deemed most important by multi-unit managers were human resources skills and organisational behaviour skills including motivation, delegation, communication and leadership. They added "in an indirect manner, the multi-unit manager is responsible for the multiple organisational outcomes of each of the units under his or her jurisdiction and must change management styles accordingly."

We also observed that the skills involved in running a corporate centre in networked organisations are different from those required to run an operating unit. In some cases the leaders at the centre were not necessarily subject matter experts in the core business but brought strategy, logistics and other skills. The ability to take a high level view and resist the temptation to intervene, and the ability to manage across wide distances and even time zones, were very important.

3. There is generally a clear distinction between a set of tasks that are to be done centrally and a different set of tasks where individual operating units are allowed discretion, though this distinction is subject to debate.

The vast majority of organisations have identified a set of core functions that are delivered by a corporate centre or sometimes at a regional level in larger organisations. These tend to include governance, procurement, HR and payroll, IT and estates and property management. Communications and brand management are also generally managed centrally and there is usually some form of programme to oversee product development and/or the identification and dispersal of innovative practice.

Concerns about brand, reputation and governance were central to leaders operating at the corporate centre. Most said that ensuring compliance with governance requirements across multiple sites was the single issue that kept them awake at night.

By contrast, local unit managers are usually given clear responsibility for ensuring high quality customer experience and for commercial decision making in relation to local market characteristics. Ensuring high customer satisfaction is usually seen as a critical role for local units to lead on. That said, the allocation of roles and responsibilities between the centre and the outposts is seen as a dialectic with different solutions that can change over time and depending on circumstances. Several organisations changed the balance between centrally mandated and delegated functions depending on factors such as the performance of individual units. Others allowed outposts flexibility to make certain recruitment, remuneration and procurement decisions, as long as these remained within specified budget ranges. The decision about whether tasks are performed locally or centrally was considered to

be "highly emotional because it challenges sovereignty". Similarities and differences in approach can be observed in the descriptions of practice in different sectors below.

An interviewee operating in the private healthcare sector said: "The arrangement for what is devolved and what is kept central is constantly evolving, but the structure is flat. The mindset is a constant iterative process about what is done once and what is done locally. Unless you can absolutely make the case, you don't centralise. You really have to be clear about criteria for centralising, such as scarcity of expert skills."

An interviewee operating in the casino and gaming sector said: "There is lots of autonomy on the people side, some on the product, very little on the physical infrastructure, IT, property etc." In some areas of the business, unit managers are allowed to influence the type of product offered and also offer own label products and pricing, because this is a function of local market competitiveness. Most marketing spend is devolved within this sector.

An interviewee operating in the academy schools sector told us: "We're very clear that we're not Marks & Spencer and McDonalds. Each [school] has its own ethos and feel because we wanted the leaders of these places to feel that they were responsible for running them and it wasn't down to a head office… The balance between local autonomy and central control slides back and forward. As [individual units] become more successful, the more differentiated they become."

An interviewee whose business is in the pub and restaurant sector said: "The big areas of the business from a profit making and legislative point of view are not the areas that you would want to leave devolved... But areas such as who was recruited, how the service was delivered, were absolutely crucial [from a local perspective]. We put a lot more emphasis on service scores, bonused on service scores and started talking to the City on service scores. Whilst the managers might have felt that they lost [responsibility for] pricing and products on the bar, we put much more emphasis on the service side of the business... When menus were being created, you'd have people involved at every level in workshops giving feedback. It's just that ultimate decision-making right had fundamentally changed."

4. The role of the operational manager at each operating unit is seen to be crucial to the success of the chain.

Rather than site managers within a chain being viewed as having a diminished role, corporate leaders viewed these individuals as being fundamental to the success of the overall organisation. This is both in terms of their ability to ensure that their unit reflects the values of the chain, and often also in terms of their ability to influence the strategic objectives of the chain.

An interviewee operating in the casino and gaming sector offered the perspective that in his industry "customer experience is consumed where it is bought" – a principle he felt it shared with health care. He said: "Front line teams are a critical part of the experience and the general manager has a significant impact on front line experience in terms of the kind of people they recruit, the motivation of front line teams, reward and recognition of front line teams." The key point is that there is no second chance to provide a good experience if it is not done right first time. This necessitates an approach where local managers need to have a high level of discretion to fix issues about the user experience as quickly as possible and without reference upwards.

A further interviewee from the private health care sector told us: "Each site is run by one person who accounts to the director of secondary care. Site managers are pretty autonomous and there is a highly devolved structure, against which a number of areas are ringfenced, which are done in a programmatic way and at scale."

Interviewees gave us examples from both their own and other sectors where local unit managers had significant autonomy in areas such as discount pricing, business development and designing local product offers. One interviewee particularly admired a company operating key cutting outlets, which he said allows store managers freedom to negotiate bulk discounts with customers, with the head office managing performance against margins rather than adherence to fixed pricing policies.

5. Running an effective multi-site organisation requires extensive standardisation of management systems and functions.

At the same time that some areas of operation are subject to high levels of autonomy in chain organisations, products are generally provided in a highly systematised way, whether through the use of 'templated' formats, design books, or similar. Standardised operating frameworks, procedures and policies are used, the expectation being that these will be adhered to unless there is a very clear reason why another approach is required.

Interviewees were generally very clear about the specific circumstances in which standardisation could offer benefits, and where these were evident, they were unafraid of requiring outpost units to comply with very prescribed processes. This was described by an interviewee operating in the private health care sector as follows: "Functions that are traditionally second division functions in NHS management are amplified in a diversified model because you need estates, facilities, HR, etc, to be operating in an environment that you're not completely controlling. There is quite a lot of low level administrative grunt that we value very highly."

Organisations wishing to implement more standardised processes often went to some lengths to demonstrate the value of these approaches to employees at outpost organisations and to create an environment where there is an opportunity for senior professionals to have an input into designing the processes, specifying the performance of product and choosing some items.

One interviewee working in the legal sector said: "We try to operate a standardised approach. We position ourselves as a national business. Therefore you should expect to get the same level of service wherever you touch it… We told the workforce that was what needed to be done. Having very fragmented business units was making it very difficult for us to sell our services and operate consistently."

One provider of healthcare locates centres of excellence for the chain at individual hospital sites. These lead on setting policy across the chain for their area of expertise. The same provider ensures that the top clinicians in a service area work with a centrally based procurement lead on the procurement of devices for the chain.

Others working in health care internationally have reflected that sometimes the relative lack of standardisation within health care providers can mean opportunities for improvement – in other words to spread high quality practice - are lost. Gawande (2012) contrasts the highly systematised working practices at US restaurant chain 'The Cheesecake Factory' with working practices in the country's health care sector. He identifies purchasing at scale, centralising common functions, and adopting and diffusing innovations quickly as practices that could be adopted in healthcare. He admires the restaurant chain's approach of standardising its offering and specifying the components and objectives while allowing some discretion about the processes to achieve the output.

Gawande states: "In medicine too, we are trying to deliver a range of services to millions of people at a reasonable cost and with a consistent level of quality. Unlike the Cheesecake Factory, we haven't figured out how. Our costs are soaring, the service is typically mediocre, and the quality is unreliable.

Every clinician has his or her own way of doing things and the rates of failure and complication (not to mention the costs) for a given service routinely vary by a factor of two or three, even within the same hospital."

6. Effective multi-site organisations usually deploy significant effort in 'talent management', management development and organisational development.

Most organisations interviewed devoted significant resources to ensuring that local unit managers were supported, felt empowered and enthused and were well-linked up with other parts of the system and peers in other units through strong lateral relationships. Many organisations used job area-specific away days, virtual networking, and professional development programmes to foster relationships between people working in similar roles at different sites across the organisation. Employees are often encouraged to use these networks in their day to day work. In some professional services firms and to some extent in some private healthcare there are lateral links between operating units based on areas of specialist expertise. These develop the standard approaches, feed into procurement decisions and help to ensure a more uniform approach to how business is done (see Case Study 1).

In most cases, there is a clear emphasis on organisational development, driving people management, training and performance development. Many of the unit managers have worked their way up through the company into the positions they occupy, supported by extensive systems designed to identify and nurture in-house talent.

In organisations that are in transition to a new way of working, with a greater emphasis on templated working arrangements, much of the time of senior leaders has been spent on change management, working closely with human resources and communications colleagues, and often becoming closely involved in implementing strategic plans and resolving workforce issues. Individuals in such roles (and those in regional leader roles at larger organisations) can find themselves spending large amounts of time on the road, visiting local units.

Principles of good 'followership' are emphasised within these organisations at least as much as principles of good leadership. Evidence from successful organisations supports the theory that empowering and valuing local unit leaders improves performance.

Several authors emphasise the importance of ensuring that staff working at individual units feel empowered and are able to take ownership of their work. Umbreit and Smith (1990) find that successful multi-unit managers "place a high value on the development of managers, including the training and recruiting functions". In particular, successful multi-unit managers were found to support unit managers to manage their own restaurants; let managers establish their own goals; develop managers, assistant managers and crew; motivate and establish pride and team spirit and model the work ethic.

> **Case study 1: lateral links and standardised approaches in highly professionalised industries**
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> A national legal services provider has increased its efficiency by standardising the documentation used across its offices and establishing closer links between its experts operating at different sites.
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> Lawyers working within each service line share information using organisational wiki pages, and there are training days where staff within service lines meet up, as well as regular video and voice conferences.
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> The company operates several service lines, each relating to different areas of law, with specialists in each field working in each of its offices. It has adopted a standardised process to ensure that the same contract models and precedents are deployed across the company, and that these are based on common standards set by a centralised knowledge learning and development team, and experts in each field. These experts are each based in a local unit and spend most of their time working in that local setting, but they are centrally funded. They provide a focus for knowledge sharing activity across the network in their area of expertise, organising training updates, lunches and away days, and help to induct new members of staff.
>
> Leaders feel that staff have been convinced of the need to operate more standardised processes because they can see the efficiencies this generates. The approach is underpinned by a collaborative culture and strong corporate values around providing a high quality legal product.
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> As a result of the greater standardisation and better established links between offices, local staff are able to benefit from the support offered by stronger networks with peers elsewhere in the country. The approach has also enabled the company to respond more effectively to peaks in demand, as staff working at different sites are familiar with the documentation being used by their colleagues and can therefore support them at busy times.

7. Effective chains have clear processes in place for internal quality audit, in order to ensure compliance with governance requirements. These internal quality audit units generally operate at a national or regional level and sit within the overarching corporate structure rather than being located in operating units.

All interviewees had internal processes in place for measuring and maintaining quality. An 'across the board', centrally led process is generally applied for ensuring compliance with statutory requirements, and also internal performance guidelines. Processes tend to comprise inspections by third party agencies (such as for health and safety legislation compliance) and/or site visits by internal compliance and quality audit teams located at the central operating unit. In larger organisations, there may be a regional compliance audit function. These internal quality audit processes were usually viewed as distinct from external regulatory activity, and were often considered by leaders at these organisations to be more effective than inspections by regulators at assessing performance.

One private health care provider said: "There is a national dashboard that goes to all hospitals – never events, near misses, patient complaints. There's also a site governance meeting at least on a quarterly basis, mostly on a monthly basis. This is a mixed group including clinicians."

The approaches deployed depend in part on whether newly acquired units have been deemed to be 'failing'. In such cases, central operating units can be quite interventionist, deploying staff from a central pool of turnaround specialists to work at the unit and model successful behaviours until results improve, or providing heavy internal audit scrutiny. In some cases, performance against these auditing arrangements is linked to the amount of freedom afforded to individual operating units by the central unit.

Performance in internal and external or regulatory audits is monitored closely and taken extremely seriously, both at the corporate level and at local unit level. That said, a focus on ensuring compliance with regulatory requirements does not necessarily imply support for the regulatory approach being used and some interviewees told us that they preferred their own internal audit processes as a means of effectively identifying and addressing performance issues. Interviewees told us that a deterioration in performance would lead to increased scrutiny from the central corporate unit. This could involve more frequent inspections, intervention from central quality improvement teams, reduced autonomy and restrictions on the activities that could take place at a site and even the parachuting in of turnaround staff either from a central resource or from elsewhere in the chain.

That said, governance and compliance was the area that tended to cause the people we interviewed most concern and they acknowledged that it was not possible to know everything about what was happening at every site at all times. Instead the emphasis was on having approaches to identify problems and resolve them quickly.

Case study 2: auditing quality and ensuring compliance with governance requirements

A national nursery provider has instituted two tiers of internal audit in addition to the site inspections undertaken by sector regulator Ofsted.

A programme of internal audits is run from the organisation's central business unit. This programme operates in a similar way to regulatory inspection, but the audits are used for the organisation's own quality monitoring purposes and to identify ways for individual operating units to improve their performance. Depending on the results of this internal audit, the Ofsted audit and the nursery's financial performance, each nursery is allocated to a specific tier within the organisation. The amount of freedom the nursery receives – for instance in terms of freedom to recruit new staff – depends on which tier the nursery is allocated to.

In addition to this, there is a peer group audit process where groups of nursery managers from different regions visit nurseries outside their region. They produce a written report summarising their observations of what works well and what could be improved. As well as being useful for the nursery that is the subject of the report, this also helps the visiting managers to reflect on what they could be doing better at their own sites.

The peer to peer audit is described as one of the most useful tools at the organisation's

disposal but also the one that took the longest to implement. Its success hinged on staff trusting management and management demonstrating a clear focus on supporting staff to improve quality.

8. Successful chains have clearly defined processes for capturing, testing and dispersing innovative practice.

Almost all organisations interviewed have processes to systematise the spread of innovation that have been designed to avoid situations where innovative practice has not been capitalised upon. Approaches deployed were conceptually similar, consisting of a process of experimenting and testing, perfecting and then implementing across the group, but there were different approaches to execution. Some organisations had systems that identified areas where innovation would be prioritised for business development reasons and sought out innovative practice in these areas. Others operated in a way that was more reactive to emerging innovation at local outpost units. All schemes were designed in such a way that central resource would be made available to support the testing of an innovative idea. They also shared in common a rigorous roll-out process once an innovative approach had been approved for adoption. Local operating units would be expected to adopt the new approach unless they could demonstrate a clear reason why it was inappropriate.

One interviewee described their own organisation's process as follows: "Innovation is built by experiment and testing. Innovative practice is perfected and then implemented rather than being 'spread'… Once we think something's good, we do it. We don't have cultural baggage."

Another organisation has designated experts within each sector area that it operates in. These experts are based at different outpost locations, but their posts are centrally funded. They are tasked with maintaining strong links with staff operating in their field of expertise across the chain.

One further point at which there is an opportunity to capture innovative practice is when a new unit is incorporated into a chain. Interviewees were keen to stress that acquired units often had practices and processes that were of interest to the acquiring organisation. Capturing this intelligence in order to roll it out across the wider chain was therefore often another specific component of the process of incorporating a new unit into the chain.

Allowing individual operating units the autonomy to come up with innovative ideas, whilst at the same time capitalising on the benefits of standardisation, is a particularly complex task. Chang and Harrington Jr find evidence of a trade-off between allowing local units autonomy to develop a business strategy at an operating unit level and ensuring that good practice can be shared.

They state: "Developing the manufacturing process to best meet the needs of one's customers may enhance demand and profit. However, it will also result in plants (units) modifying their production (business) processes in different ways which makes innovative ideas less transferable between them and can have a deleterious effect on the overall performance of the organisation… Heavy handed intervention from corporate headquarters may not be necessary for the right strategies to emerge but rather careful instruction and information dissemination so that unit managers choose for themselves what is best for the firm."

An organisation operating in the casino and gaming sector has created an approach that uses four dimensions to ensure that innovative practice is successfully identified, tested and dispersed across its sites.

The first element is about facilitating innovative practice. Here, information about trends, new ideas and platforms for ideas is shared. Support such as workshops, access to expertise and test environments is made available. Seed funding is also provided, along with training and web-based tools for cross fertilising ideas.

The second aspect is about cultural change and 'leading from the top'. Innovation champions have been put in place across the business and there is a central approach to setting up innovation road shows and to ensuring innovation is built into employee objectives.

Third, there is a process for identifying relevant new ideas. These are aligned with strategic priorities in order to ensure that new opportunities are explored systematically.

Fourth, a 'gated' approach is applied to brand and product development. This is described as being a similar process to those used when new IT projects are under development. It comprises 'ideation', evaluation, preliminary investigation, concept creation, concept refinement, initial design, testing, further development and testing, final specification, launch and review.

9. Making the transition from a single site or collection of autonomous units to a more standardised chain operating model will require large scale cultural change. This presents a significant management challenge in its own right.

Leaders we spoke to had often overseen a process of moving towards greater standardisation between the units in their chain. Usually this shift had been determined in order to streamline the business, but meant significant changes to the way staff worked, which were not always popular.

Successful transitions were achieved by maintaining a clear sense of direction and ensuring the senior team was very visibly leading staff in the change and demonstrating the new behaviours. HR teams often played a significant role, setting up retraining programmes for those whose roles were different as a result of the changes. In an example from the pub and restaurant sector, unit managers who were used to having a greater degree of autonomy gave up responsibility in areas such as finance and property more readily, because these functions were seen as requiring particular professional skill sets. There was more reluctance from individual operating unit managers to adopt a standardised commercial and marketing strategy as they felt this to be within their area of expertise.

One interviewee working in the pub and restaurant sector described these tensions and the way the executive team dealt with them as follows: "The transition from a devolved structure to a centralised approach raised some challenges. Pub managers can often be driving multi million pound businesses and have 30 to 40 employees on their books. They are people of calibre who think quite rightly that

they understand their consumer locally and want to make decisions about stock and staffing. That's the way the pub business was 20 years ago and every year that's being taken away from them…

"The chief executive and leaders in the business have got to have one very clear agenda and must try not to overload staff with other issues and thoughts. Communicate early, stand very strong with the team and the organisation to state that this is the strategy and the operating structure that goes with it. Communication is important."

10. There is a high level of risk associated with transactions to add operating units. This requires a very substantial investment in due diligence and to integrate units. Caution is required about any policy which reduces the incentives to assess risks correctly.

The view from interviewees was that a chain 'bet the farm' when taking on new units, and that bringing new units into a chain had appreciable and usually unavoidable risk, whether starting from scratch, taking over another company or acquiring a failing organisation. It is also clear that the approach to growth is either by developing new operating units or by acquisition rather than merger.

Successful due diligence processes were viewed as absolutely critical in making this work. It is important to note that due diligence is considered to have been undervalued in many NHS consolidations of recent years.

Of the individuals we have spoken to, most have been involved in all of these types of expansion to differing degrees. Unsurprisingly, starting up a new site from scratch is viewed to be the least challenging approach to expansion. A takeover of another company, incorporating its units into the existing company's portfolio, is considered to present cultural, and logistic challenges that need to be addressed urgently in order to achieve a smooth transition. In some sectors (schools and healthcare) there was a strong aversion to acquisition where the professionals in the acquired unit were not in favour.

For acquisitions of 'failing' organisations, there is an added aspect of ensuring that risks relating to the failing units are quickly mitigated. As with existing approaches to merger and acquisition, comprehensive due diligence processes are seen as absolutely key, as are very large scale and detailed change management programmes, with clearly specified targets and milestones, that begin as soon as the transaction is complete, and are finalised well in advance of this point. Running two strategies and structures in tandem is viewed as very inefficient and absolutely to be avoided.

Describing his organisation's process for integrating a smaller chain that his own organisation had acquired, an interviewee operating in the casino and gaming sector said: "The principle for us is hearts and minds. Most of the effort was face to face with the people impacted by the acquisition. We engaged cashiers in the acquired units using cashiers in the existing units." In all the cases we found the level of investment in pre-integration planning and post-acquisiton organisational change was very significant, extremely rapid and on a large scale using a significant amount of managerial resource. Interviewees with experience of both the NHS and other sectors commented on the difference in approach with the NHS appearing to underinvest in these areas by a significant amount.

Significantly, interviewees felt that they were able to say no to a potential acquisition, where they considered the business case was weak. Even in the academy schools sector, where there was felt to be pressure to expand more quickly, interviewees were clear about the need to undertake effective due diligence and not to overreach.

Further findings

In addition to these main characteristics, there are further approaches and methods that some or all successful chain organisations have developed. Details of these are provided below:

Procurement

As described earlier, procurement is almost exclusively carried out centrally, on the basis that this generates the greatest economies of scale. Where some local discretion is allowed, this will generally only be in a specific area, and cost parameters will be applied. As already stated, chains can build support for centralised procurement processes by enabling professionals working at operating units to have an input into decisions about which products to procure. For instance, some private healthcare providers told us that panels comprising senior professional/clinician staff from across different sites were established to work with corporate procurement leads on identifying the best prostheses.

One interviewee in the private health care sector said: "Procurement is all centralised. That, we regard as back office. Getting deals and complying with deals is led from the centre. There's no point in doing it 66 times… If you take a hip or knee replacement, any prosthesis used needs to be within a cost range. Any outliers would be reported on, on a regional and then central basis."

IT/data

Several organisations interviewed felt that there was more to be done to get their IT and data strategies right, sometimes adding that these had received insufficient board level scrutiny. Where successful IT and data strategies exist, these make available current information that is frequently updated. Importantly, this is then used prospectively as an 'agenda for change' rather than retrospectively to analyse what has happened in the past.

In some cases, chains located data management officers within each individual operating unit. These individuals were charged with ensuring data was collected, subject to the correct local analysis and shared with the central unit, in order to facilitate this prospective approach to data analysis.

One academy schools chain was using data capture to drive specific outcomes. On intake, pupils are profiled and tested to assess their standard. Targets are then set for each pupil. Our interviewee told us these targets were determined on the basis of the grade individual pupils needed to get to obtain 'good employment' and the performance they needed to achieve year by year to obtain that grade. Each school has a 'management information system officer' and a standardised information system operates across the chain. The data is collected on a site by site basis and shared with the central management tier. Data is 'plugged in' to the chain's database every six weeks and analysed using criteria such as pupils' ethnic group, gender, attendance rates, and level of social deprivation. If a problem is identified within a particular category of pupils, an intervention takes place. As well as analysing this data using demographic criteria, the chain is also able to view performance by department.

Where chains have acquired new operating units, specific challenges around system interoperability come into play. Rather than embarking on costly processes to migrate incoming units onto new software and train staff to use it, one organisation had developed the tactical solution of setting up its own data warehousing system, which is compatible with multiple IT systems. This means that information about newly acquired units can be analysed alongside the existing operating units much more easily.

Estates/property

Among the organisations we interviewed, estates and property was almost always a centrally managed function, though 'hotel services' would sometimes be devolved with a local head of housekeeping type role.

HR/payroll

HR and workforce strategy is generally centrally led, but much of the day to day activity takes place at local operating units. For instance, although many chains had processes in place that required operating units to get authorisation from the central unit in some instances – for example before recruiting to a new post or substantially increasing a salary - only one of the 11 chain organisations studied handled the entire recruitment process centrally. Line management activities were carried out at the local organisational level for the vast majority of staff. As stated earlier, having a clear HR strategy is viewed as particularly important when an organisation in the process of moving to a more systematised working approach.

Communications, branding and reputation

Stewardship of the overarching organisational brand is handled centrally. Communications is viewed as a corporate function, alongside strategy.

Branding is an area where divergent approaches are seen. Some organisations consider it important to ensure that newly integrated operating units operate under the new brand immediately, in order to emphasise the shift to a new way of working. Others use a gatekeeping approach, motivating acquired units to improve by only allowing them to adopt the overarching corporate brand when they have attained a specific performance standard. This also safeguards the corporate brand against reputational damage as a result of historic problems.

Geography

Opinion is divided about whether it is possible to operate a chain across a geographically disparate area.

One interviewee felt that it was possible to operate across a wide area, using intensive quality audit processes, but accepted that this placed a burden on senior staff in terms of the amount of travelling expected of them. Other organisations operating across dispersed networks were making extensive use of videoconferencing, organisational wikis and other technological solutions to enable people to work together across large distances.

However, an interviewee operating in the academy schools sector, whose business model requires his organisation to take on failing standalone entities and subject them to fast, intensive turnaround as part of his group, felt that operating across a wide area would not be possible, because he would not be able to deploy his central team of expert professionals in the way he does now. At present, these people take up interim posts in challenged organisations until results improve. The significant difference here appeared to be the level of interconnectivity within the operating approach, which manifested itself in terms of a requirement for staff to move easily between sites.

Views and experiences from the NHS

NHS leaders' views on the benefits and challenges of chains

In order to test the relevance of our findings to the health service, we interviewed a group of NHS leaders, providing a brief overview of the characteristics we had identified and asking for initial reactions. A limitation of this approach was that interviewees had limited time to reflect on our findings and their comments were therefore understandably influenced by their own recent experiences. Further exploration of the strategic value of multi-site operating models within the NHS may be helpful at a later stage in this programme of work.

NHS leaders interviewed generally considered that traits of multi-site organisations identified above could have some relevance in an NHS context. Interestingly, some of the methodology was already in use within the NHS, particularly where acquisitions had taken place at some geographical distance. Two chief executives that we spoke to were already operating many of the principles described in the first section of this report, and were using an approach that involved an overarching central unit and devolved operating units to some degree. One chief executive whose organisation had recently acquired another unit explained that he had begun to view his own organisation as a small chain and described a common system, expectation and discipline as being essential for operating these type of arrangements within the NHS – a conclusion that our interviewees from outside the sector would be likely to support.

This chief executive's organisation had articulated its offer to the provider that was to be acquired in terms of the systems and processes that could be applied at scale across the two organisations. These included a systematic approach to managing clinical services, access to an IT platform, effective organisational development and HR management processes. He was very clear about the fact that had the acquired organisation not been a willing party to the transaction, the change would not have gone ahead.

This chief executive had found that as leader of this small multi-site organisation, his relationship with his own organisation had changed. He had appointed directors of operations for each site, reporting to him, and each site now had a hospital board.

The two main sites operated under a shared approach to governance and quality audit and had a common strategy and strategic outlook. A compliance unit working across both sites carried out a process of internal assessment and analysis in the risk and legal areas. In this and other similar cases the importance of geographical proximity for the management of some types of care was important.

 There was support among the NHS leaders interviewed for the principle of adopting an approach that retained a senior unit manager role. Another chief executive described a lack of local senior management in acquired units as one of the main downsides of the current NHS approach to acquisition. She thought that a model that retained a local senior presence (the operating unit leader) would be more suited to the requirements for local stakeholder engagement work (for instance with local authority leaders, Health Watch, clinical commissioning groups, etc) that would be a characteristic of an NHS chain. This point also applies to the principle raised by earlier interviewees that where a service is consumed at the point of use, there needs to be senior enough decision-making capability on site to be able to make decisions and address problems quickly and autonomously.

This chief executive also saw distinct roles for a corporate centre and outposts within the NHS. The role of the corporate centre would be to "create a clear sense of corporate value and corporate philosophy". However, another NHS interviewee remarked that individual NHS organisations have not focused on the development of brand and corporate values, perhaps viewing this activity as being at a remove from the core tasks of providing high quality care and complying with regulatory and

commissioner requirements. It is possible that a move towards multi-site operation will require greater consideration of these issues from those setting up and running chains, who will need to be able to articulate the values of the chain in order to attract other organisations to join it.

More than one interviewee suggested that moving away from an approach where business areas such as procurement and payroll were overseen at every site could be beneficial to NHS organisations. Previous attempts to mandate such changes centrally have met with resistance and the benefit case for centralising these functions within a chain will need to be clearly articulated, with demonstrable results.

One chief executive suggested that in addition to the practical benefits described above, the chain model offered an opportunity to move beyond the "emotional, aggressive" takeover mentality to a more positive, developmental, values based process. This had the potential to generate more support for reconfiguration from staff, though this would only be the case if leaders demonstrated a genuine commitment to these values. She said: "If you're trying to get highly professionalised organisations where people have lots of autonomy to work together, you have to engage with them in the right way."

However, NHS leaders were clear that the chain model was not a panacea, and should not be treated as such. One interviewee stated that joining a chain would be a good way for some providers to gain access to high quality practice and share a 'unique selling point', enabling them to demonstrate a competitive edge. But she felt the model was not suited to addressing deep seated financial issues as it would not be able to generate sufficient economies of scale to address liabilities such as historic PFI commitments.

Leaders also queried whether the incentives underpinning assumptions that NHS organisations would wish to set up or join chains were strong enough. One deputy chief executive could see the benefit for organisations looking to join chains, but was less convinced of the arguments for high performing organisations to bring them into their group. This was particularly so given that struggling NHS organisations often face significant structural challenges requiring more fundamental actions than a simple change of management approach would be likely to provide.

Another chief executive who had been participating in a buddying scheme described non-executive directors' anxieties about risk and liability within those less formal arrangements. Such anxieties may prove to be a barrier to structural relationships between providers across distances, though this chief executive felt that such arrangements should be possible.

Ways to support NHS organisations exploring possible chain arrangements

From conversations with both sets of interviewees, it is clear that a certain tasks must be completed to a high standard before entering into an agreement to form or join a chain. In particular, there must be careful consideration of the risks facing each organisation as a result of any transaction or different working arrangement.

A high quality due diligence exercise must take place, resulting in a decision about whether or not to proceed and, assuming the decision is positive, a detailed implementation plan. Organisations concluding that entering into such an arrangement would not be in their interest, must be permitted to say no. In order to complete this process successfully, the stated aims of the arrangement must be clear, and any unstated aims must have been identified and addressed – either by building them into the acquisition plan as a stated aim or stating that they are not an objective of the proposed approach.

There are valid questions about whether there exists sufficient capability and expertise within the NHS for these due diligence exercises to be conducted in house. However, the decisions that will need to be taken will be so context specific, and the points at which they are made so infrequent, that we anticipate that the creation of a formal decision aid or tool for deciding whether or not to enter into multi-site working arrangements might not represent best value for the service.

NHS organisations will need to identify the goals that they are seeking to achieve by entering into a chain arrangement, to identify the organisations best suited to join with to achieve those goals, and to carry out effective due diligence around the transaction. It is likely that they will require some support to complete different aspects of these tasks, but we believe that this would be best provided on a case by case basis, focused on the specific circumstances in question.

3. Conclusions

Two distinct sets of lessons have arisen from our research – the first relating to the establishment of chains, and the second addressing the day to day operation of a genuine multi-site organisation, rather than running an additional site that will be managed from the 'parent' unit.

The first set of lessons largely reinforces existing knowledge about the importance of strong merger and acquisition processes. We heard a clear message from those we interviewed both outside and within the NHS that robust and effective due diligence and risk assessment processes were essential when embarking on transactions.

Although in the case of the multi-site organisations we spoke to, the transactions in question were to bring new operating units into a chain, rather than to incorporate one organisation into another, the consistency of the message underlines the importance of effective governance around transactions.

This extends to clarity of purpose and a 'no surprises' approach. Boards must ensure that aims and objectives relating to setting up chains are clearly stated and that no unstated and untested assumptions are allowed to influence the decision-making process. Interviewees were clear that as a corollary to this, organisations must be able to walk away from a transaction if they decide the business case is too weak to enable them to proceed.

The second set of lessons points towards potential for a significantly changed approach to operational management within the NHS, which is different culturally, operationally and structurally.

Our research with leaders working in multi-site organisations outside the NHS suggests that successful chains have been able to disperse high quality and innovative practice more effectively, reduce some costs and develop collegiate working practices. The mechanism for achieving these gains appears to be a shift to a management system comprising a central strategic engine distinct from local operating units.

This corporate centre must have sufficient influence on its outposts to ensure that systematised approaches to product delivery are effectively rolled out across the chain, and that where functions are managed centrally, these policies are adhered to.

It must also be able to inculcate and maintain a collegiate organisational culture that values staff and fosters lateral relationships that are strong enough to overcome both geographic distance and 'psychological distance' generated when responsibilities and accountabilities change.

Similar achievements may be possible for NHS organisations adopting genuine multi-site approaches, but any benefits are likely to be limited to improved dispersal of high quality and innovative practice, limited cost reductions and better lateral links within organisations. It is unlikely that multi-site operating models will be able to leverage sufficiently large cost savings to mitigate fundamental structural issues affecting the sustainability of provider organisations or offset historic PFI debts. It is therefore our view that these models should not be viewed as a 'silver bullet' solution to some of the more fundamental financial and sustainability challenges facing the NHS provider sector.

There are also outstanding questions about the extent to which multi-site organisations can operate across large geographic distances. This was the area where there was perhaps greatest disagreement between our interviewees in organisations outside the NHS, with some stating that operating in disparate locations posed no challenge to their business and others indicating that it would not be possible for them to operate their business model across wide distances. We suggest that no simple answer exists in relation to whether or not geographically dispersed models are feasible, but workforce structure will be a significant factor, as will the degree to which the central management unit wants the individual operating units to offer services in an interconnected way (as opposed to offering them in the same way). For instance, we would anticipate that some more complex areas of provision and some emergency services might need to operate as part of a network, often with local support.

NHS providers wishing to embark on building chains will need to ask searching questions about whether they have access to the right expertise in house, both in terms of undertaking effective processes relating to the transaction and in terms of the operational and logistic requirements of working across multiple sites. Where they conclude they require additional expertise, they will need to access external support.

It would be a mistake to view joining a chain as being a less significant transaction than a merger or an acquisition. That said, the long term opportunities that effective multi-site networks appear to offer to generate and disperse innovative and high quality practice are attractive and merit further exploration by the NHS.

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