



Chapter 1: Why Work in Partnership?

HEALTH, SOCIAL CARE AND HOUSING PARTNERSHIP WORKING

BRIEFING NOTES FOR PRACTITIONERS AND MANAGERS

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This series of brief guidance notes is aimed at helping managers and practitioners understand and apply the evidence of best practice in partnership to their own practice. Based on extensive review of the literature, it provides short and practical guides, with review questions on:

- 1. Why work in Partnership?**
- 2. What is Partnership?**
- 3. The Scottish Policy Context for Partnership**
- 4. Barriers to Partnership**
- 5. The Characteristics of Successful Partnerships**
- 6. Partnership Assessment and Development Toolkits**
- 7. Bibliography.**

Full references to works cited are given at Chapter 7

INTRODUCTION

The concept of Partnership is accused of being ‘motherhood and apple pie’ – an irresistible concept, which is intuitive common sense, rather than having any concrete evidence base. Because of that, its effectiveness – in particular, its cost effectiveness– is questioned.

(Edwards and Miller, 2003; Glasby and Lester, 2004; Glendinning, 2003; Gordon and Walsh, 2005; Kharicha et al, 2004; Maguire and Truscott, 2006; Strachan, 2005 and Thistlethwaite, 2006).

This chapter seeks to:

- Identify why people enter into partnership – what outcomes are they seeking to achieve?
- Establish whether partnership working actually delivers the sought-after improvement
- Weigh up the evidence for and against the efficacy of partnership working and the quality of this evidence;

The literature reviewed was a mixture of research studies of partnerships in action and official sources – the National Audit Office/Audit Commission, etc. based on their own compilations of inspection reports and guidance. A full bibliography is at Chapter 7 of this series of Briefing Notes.

WHY DO PEOPLE ENTER INTO PARTNERSHIP?

One key motivation for working in partnership is to achieve more than could possibly be achieved by any stand-alone organisation – the whole being greater than the sum of the parts. (Edwards 2007, Armistead & Pettigrew 2004, Keele and Strathclyde 2006, Huxham and Vangen 2005, Thorlby and Hutchinson, Audit Commission 2005, Effective Interventions Unit 2003, Carley 2006).

This concept is central to Huxham and Vangen’s (2005) notion of *collaborative advantage*, in which both the common goal *and* the individual goals of companies or organisations are forwarded by collaborating – in particular, they refer to the ability for partnerships between public sector organisations and those with non-profit organisations to ‘tackle social issues that would otherwise fall between the gaps’.

Below is a summary of common **drivers for entering into partnership**:

1. **To tackle complex problems** (sometimes referred to as ‘wicked issues’¹) - which cross traditional organisational boundaries and which agencies have

¹ The concept was originally proposed by Rittel and Webber [1973] in a paper on social planning, and has since been developed by other writers. (Hudson, 2006, p6.)

to tackle together. Wicked issues are hard to define, with complex inter-dependencies and causal links which are difficult to untangle. They can include community safety, economic regeneration, health inequalities, social inclusion and also more specific problems such as delayed discharge and unplanned admissions.

2. **Service change and improvement** through addressing some of the failings of ill co-ordinated services – changing ownership of cross-cutting problems from ‘someone else’s’ to ‘ours’. Mechanisms which partnerships use to tackle these change and modernisation issues include: clinical pathways; development of intermediate care models; protocols for common procedures; outcome-focussed strategies for specific user groups (such as older people, people with learning difficulties or people with physical impairments), whose needs often call for a co-ordinated response from a range of agencies; person-centred care; supporting independence
3. **Gaining advantage from pooling learning**, building workforce capability, skills and expertise, information exchange, joint training and also shared risk.
4. **Gaining financial resources** – either through bids to grant giving organisations who require a partnership approach, or pooling of resources for efficiency or economy. (Although Carley (2006) found that partnerships stitched together simply in search of funding tend not to work, whereas local, voluntary partnership stands the best chance of succeeding)
5. **In response to a perceived threat** – e.g. to avoid a re-structuring in a different direction, reduce the impact of organisational fragmentation and minimise the impact of it
6. **Legal obligation/government guidance** or requirement.
7. **Remedial action in response to an inquiry report**. Several high profile inquiry reports launched in response to failings in, for example, child protection or older people’s services have referred to the need to improve operational or strategic partnership working. The absence of good multi agency working has have been found to be a significant contributor to the problems being investigated – e.g. Caleb Ness; Victoria Climbié.

Sources: Audit Commission, 1998; Billing and Mallin, 2004; Effective Interventions Unit, 2003; Fletcher, 2004; Glasby and Lester, 2004; Hudson 2006 & 2007; Huxham and Vangen, 2005; Johnson 2006; Lloyd and Wait ,2006; National Primary Care Research and Development Centre, March 2007; Randall et al 2007; Thorlby and Hutchinson.

EVIDENCE OF ACHIEVING PARTNERSHIP GOALS

The table on the following page identifies, summarises and categorises the benefits which have been demonstrated as being actually *achieved* through working in partnership.

The analysis of the benefits cited is by the four 'Es' of quality: economy, efficiency, effectiveness and equity. A further analysis was made within each category of whether the benefit cited could be considered to be an input, output or outcome measure.

There appear to be significant potential gains to be made from appropriate partnership activity, based on this review of the literature. From the articles identified, those which reported original research or case studies were selected. Of these, 21 found evidence of benefits to be derived from partnership working over and above those that could be gained from traditional methods of working. 6 found little or no evidence of beneficial impact.

Most of the studies related to integrated teams, although some did cover the evidence from strategic partnerships and community planning/involvement frameworks. The articles which found evidence of benefit were typically based on small scale, qualitative studies and many were narrative descriptions of individual good practice. The articles which failed to find satisfactory evidence of benefit were typically looking for harder, quantifiable evidence of clinical or other outcome differences and dismissed process benefits as irrelevant.

These findings are consistent with other published studies (Dowling et al, 2004; Glasby et al, 2006; NPCRDC, 2007; Kharicha et al, 2004).

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	Input	Output	Outcome
Economy	<ul style="list-style-type: none"> reshaping of financial and other resource flows pooling resources increased opportunities to attract investment 	<ul style="list-style-type: none"> make the best use of available resources sharing buildings 	
Efficiency	<ul style="list-style-type: none"> reduced duplication of work increased reach through the use of partners' resources and communication channels 	<ul style="list-style-type: none"> improved targeting of resources at agreed priorities better system efficiency shared support services, procurement, integrated management, innovative administrative processes, emerging hybrid roles 	<ul style="list-style-type: none"> Improved speed of response Easier access to services without having to know the structure and responsibilities of different organisations – the 'one-stop-shop'
Effective-ness	<ul style="list-style-type: none"> a 'whole person' and a 'whole systems' approach a wider skill base for staff - access to a range of training and education sharing of data and records increased user, carer and community involvement and influence more creative approaches to problems simplifying the decision-making processes redesigning workforce patterns enhancing working relationships and 'water cooler' contact a better understanding, parity and respect for each other's skills and contribution simplified lead commissioning communication easier greater focus on core, shared goals 	<ul style="list-style-type: none"> reduced communication failure increased responsiveness to user's needs and changes in level of need clearer care planning services that promote maximum independence and quality of life for users reducing delayed discharge reducing hospital emergency bed-day use tackling intractable social issues by designing coordinated, individualised programmes - increasing their chances of success more locally sensitive services improved community equipment services innovative, enabling service responses to problems which previously caused conflict and blame improved continuity of care different professional groups focussed on common goals improved job satisfaction 	<ul style="list-style-type: none"> increased user and carer satisfaction with services a better place to live and reduced demands on emergency services improved self-management of health and participation in education improved quality of life outcome measures reduced functional decline reduced carer burden and increased confidence by carers in coverage of services reduced institutionalisation
Equity	<ul style="list-style-type: none"> increased buy-in through the combined power of partnerships attracting potential partners who may normally be out of reach. strengths and areas of expertise of all the partner agencies recognised and utilised 	<ul style="list-style-type: none"> greater engagement with local communities and those experiencing social exclusion improved access for excluded groups: Partner organisations that are trusted by a hard-to-reach audience can act as a conduit 	<ul style="list-style-type: none"> greater social integration of society's more vulnerable groups through better access to flexible community services

(Sources: Audit Commission, 1997, 1998 and 2005; Billings and Leichsenring, 2004; Brown and Cullis, 2006; Cook et al, 2007; Coxon, 2005; Department of Health, 2007; Edwards and Miller, 2003; Effective Interventions Unit, 2003; Freeman and Peck, 2006; Glasby, 2006; Hassan et al, 2006; Healthcare Commission et al, 2007; Hudson, 2005; Integrated Care Network, 2004; Kharicha et al, 2004; Kodner, 2006; Lloyd and Wait, 2006; Local Government Information Unit, 2004; Macdonald 2004; Maguire and Truscott, 2006; National Audit Office, 2001; National Evaluation Team 2007; Payne, 2000; Petch et al, 2007; Sale, 2006; Schneider et al 2001; Strachan, 2005; Townsley et al, 2004; University of Warwick et al, 2004; Wait 2005)

PROCESS VS. OUTCOME BENEFITS

There is debate between the authors reviewed about the conclusions which can be drawn from the current evidence:

On the one hand, authors report a concern about an obsession with structure and process at the expense of outcomes (Glasby and Peck, 2005). It is pointed out that not enough is known about whether or not the benefits claimed for formal structural partnerships and for integrated teams could have been gained from close co-ordination of existing arrangements (Kharicha et al, 2004).

On the other hand, a focus on largely process issues is defended on the grounds that:

- there are difficulties in attributing individual outcomes specifically to partnership actions;
- many of the process indicators often studied are distinctive features of partnership and collaboration as a way of working between organisations, teams or professionals, whilst outcome measures are as relevant and applicable to alternative systems of decision-making, organisational arrangement and modes of coordination as they are to partnerships;
- if process factors relate to the health and sustainability of the partnership, process success might be the basis of, and forerunner, to outcome success;
- healthy partnerships could be seen as ends in themselves by providing a socially desirable benefit of increased participation;
- change in partnership structure is frequent;
- it would be very lengthy and expensive to construct large scale, systematic research.

(McAspurran (2004); NPCRDC (2007) Petch et al 2007; Dowling, Powell and Glendinning (2004)

The experience in Britain is mirrored in the rest of Europe, where research in 9 countries on integrated models of working found that strategies for integration, whilst common to all countries, remain restricted to model projects with a limited time-frame, restricted finances and hardly ever any follow-up activities or appropriate evaluation (Leichsenring, 2003).

CONCLUSION

There is, undeniably, a need for more research into the outcomes of partnership and closer scrutiny of the cost effectiveness of partnership, together with – at local level - careful selection of when to act in partnership and what local outcomes are expected.

However, the impressive list of benefits already found to be derived from partnership working above, demonstrates its effectiveness for tackling some of the ‘wicked issues’ of health, housing and social care partnerships.

REVIEW QUESTIONS

- What is the purpose of your partnership?
- What benefits are you trying to achieve from working in partnership?
- By reviewing the table at page 4, establish whether you have a balance of objectives across the dimensions of quality, including outcome measures for service users, patients and carers.
- Have you structured your data collection and analysis as best you can to be able to demonstrate change in these dimensions over time and to attribute these changes to partnership working?