



Chapter 2:

What is Partnership?

HEALTH, SOCIAL CARE AND HOUSING PARTNERSHIP WORKING

BRIEFING NOTES FOR PRACTITIONERS AND MANAGERS

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CONCLUSION

1.	INTRODUCTION	3
2.	A DEFINITION OF PARTNERSHIP	3
3.	DEGREES OF INTEGRATION	4
4.	THE MAIN MODELS OF PARTNERSHIP	6
5.	CONCLUSION	8
6.	REVIEW QUESTIONS	8

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 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

Research in 2002 found that there were around 5,500 partnership bodies at a local level across England, Scotland, Wales and Northern Ireland. They can be divided into around 60 different types of partnership from health improvement to regeneration and from child development to rural transport. Partnerships may spend around £15-20 billion per year with up to 75,000 places on partnership boards. This may be a significant *underestimate*. (Sullivan and Skelcher quoted in Glasby and Littlechild (2004)).

Choosing to go into partnership – or *not* to go into partnership; selecting the appropriate type and coverage of partnership and through it achieving better outcomes for people who use services and for staff is not easy to get right. It is said by the Audit Commission (1998) to be “one of the toughest challenges facing public sector managers”.

As the first chapter of these Briefing Notes demonstrates, partnership, applied and managed appropriately, can achieve significant benefits for individuals and organisations.

It is important to have a shared understanding of what we mean by partnership and to be clear about its intended outcomes.

This paper deals with the **definition** of public sector partnership.

A DEFINITION OF PARTNERSHIP

This set of briefing papers defines partnership in health, housing and social care as:

“Two or more independent bodies working collectively to achieve more effective outcomes than they could by working separately”

(Armistead & Pettigrew 2004, Audit Commission 2005, Carley 2006, Edwards 2007, Effective Interventions Unit 2003, Huxham and Vangen 2005, Keele and Strathclyde 2006, Thorlby and Hutchinson).

This does not, however, help us place and differentiate all the different terms which are applied within the broad definition ‘partnership’. The literature contains many references to defining aspects of partnership by categorising different:

- Levels or degrees at which partnership operates
- Models of partnership
- Organisational structures vs. actions by groups of practitioners.

DEGREES OF INTEGRATION

Poxton (2003) (quoted in Glasby and Littlechild, 2004) identifies a continuum of partnership working, depending on the nature of the partnership and the outcome being sought:

- *communication* – informing each other of separate actions
- *co-ordination* – working separately, but mindful of each other's actions
- *collaboration* – working together in a cohesive way
- *integration* – working together as one agency

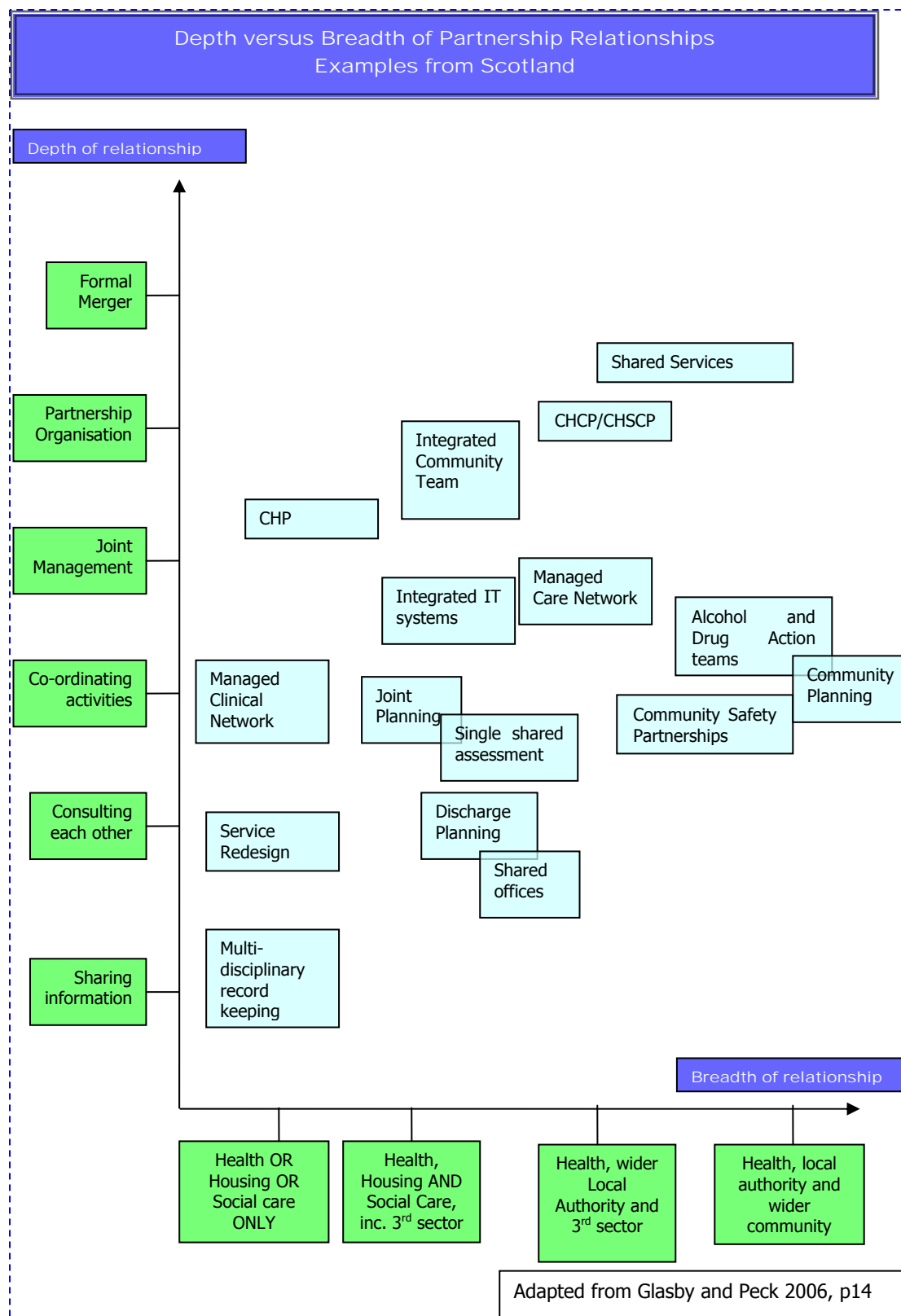
Various writers express this idea of different levels and contexts of partnership working in terms of matrices or continuums. These differ in the number and type of levels described.

- *From individual service user/ practitioner to governmental level*
- *From operational through strategic to policy level*
- *From horizontal to vertical integration* - within or between the same or different agencies
- *From less integrated (communication) through co-ordination to full integration*

(Edwards and Miller, 2003; Fletcher, 2004; Glasby and Lester, 2004; Glasby and Peck, 2006; Integrated Care Network, 2004; Komp et al 2004; Leutz, 2005, World Health Organisation, quoted in Integrated Care Network, 2004; Lloyd and Wait, 2006; Nies 2006; Poxton, 2003 quoted in Glasby and Littlechild, 2004; Whittington, 2003)

The Integrated Care Network (ICN 2004) found that integration is most needed and works best when it focuses on a specifiable group of people with complex needs and that the degree of complexity of individual needs should determine the requirement and context for integration.

The illustration below adapts the scatter plot diagram offered by Glasby and Peck (2006) to map some ways of working familiar in a Scottish context. (**N.B.** to incorporate the perspective of vertical integration within the same organisation – e.g. multi-professional teams or linkage between primary, secondary and tertiary care, an extra dimension has been added to the Y-axis of Glasby and Peck's matrix)



Note: The above example is indicative only, and may vary between partnerships, for example 'shared offices' may simply be co-location, or it could refer to single management of an integrated multi-agency team. You might want to use this format to plot where you consider your partnership sits within this matrix and whether that is appropriate to the goal of the partnership.

THE MAIN MODELS OF PARTNERSHIP

Structural forms for partnership differ - some of these are highlighted in the matrix on page 6.

The National Audit Office (2001) identified three types of partnership organisation:

- **Realigning organisational boundaries** - bringing together the whole or parts of two or more organisations to create a new organisation.
- **Formal partnerships** - working together by contract, protocol or framework agreement.
- **Informal partnerships** - working together by liaison, consultation or unwritten mutual agreement.

The Audit Commission (Nov 1998) identified 4 types of partnership, each with advantages and disadvantages, which should be considered when designing partnership working arrangements:

Separate organisation

In this model the partners set up a distinct organisation with a separate legal identity from that of the individual partners. It is most suitable for larger partnerships with a medium- or long-term lifespan and for those which need to employ staff and oversee large programmes of activity.

'Virtual' organisation

In this model, the partners give the partnership a separate identity, but without creating a distinct legal identity. The partnership may look independent, with its own name, logo and premises, and staff who see themselves as answerable to the partnership rather than to an individual partner. However, at a formal level, one partner employs any staff and manages resources.

Co-locating staff from partner organisations

This is a less formal model, where a group of staff from the partner organisations work together to a common agenda, usually under the aegis of a steering group. Sometimes the partners will pool resources to support the partnership's work, but any staff continue to be managed separately by the partner which employs them.

Steering group without dedicated staff resources

This is the simplest and least formal model. The partnership consists simply of a steering group without either dedicated staff or budget, so its outputs must be capable of being implemented through partners' mainstream programmes and staff.

Audit Commission (Nov 1998)

Managed Clinical Networks, Managed Care Networks and Obligate Networks

Closely related to whole systems thinking are the concepts of managed networks introduced in the NHS in Scotland and, more recently, across NHS and social care.

Managed Clinical Networks focus on the equitable provision of high quality clinical services, by linked groups of primary, secondary and tertiary care health professionals (vertical integration). Managed Clinical Networks tend to be condition-specific - notably cancer, CHD, stroke and diabetes - and require robust quality assurance frameworks and linkage with local management systems in order to be effective. (JIT 2008; Komp et al 2004).

It is increasingly recognised that the model for these networks has applicability beyond health, extending more widely to a range of care services provided by various agencies for different care groups (horizontal integration). Recent guidance (SEHD 2007) identifies the potential for this approach:

“Networks of the future will increasingly be multi-agency collaborations, (recognising the increasing inter-dependency of partner organisations) involved in delivery of personalised services to meet complex needs and rising public expectations. The further development of whole system change across complicated health and care organisations is unlikely to be achieved through refining traditional hierarchical structures in isolation.”

SEHD 2007, p8

Obligate Networks are clinical support networks established between remote and rural areas and larger centres to improve working relationships, increase access to care, enhance patient safety and ensure sustainability – for example, mental health and learning disability networks in Orkney and Shetland.

CONCLUSION

This paper has considered the different **definitions** of public sector partnership. It has selected a definition suitable for use for health and social care partnerships in Scotland:

“Two or more independent bodies working collectively to achieve more effective outcomes than they could by working separately”

If, however, the aim is to focus on outcomes for service users and carers and away from an undue emphasis on process issues, what is the benefit of all this debate around different terms and structures?

This is because partnership can be a painful, expensive, time consuming and risky business. It needs to be entered into for the right reasons and under the right conditions to be effective. The agreement of a common language and the selection of the route into partnership most appropriate for common goals are vital.

This group of briefing notes will principally use two terms:

- ‘partnership’ will refer to the definition above, it will also be used to describe joint planning and change mechanisms at a senior practitioner and managerial/strategic level
- ‘integration’ or ‘integrated working’, refers to operational service delivery activity seeking to work across disciplines and agencies (usually in care group-specific teams). This does not assume any model of full integration, but applies to the full spectrum of inter-disciplinary and multi-professional working

REVIEW QUESTIONS

- Think of the goal of the partnership in which you are involved or trying to establish.
- Do you have a clear definition of partnership in this particular context?
- Is that definition shared and explicitly understood by the rest of the partnership?
- Are the implications of adopting this model clear to all participants?
- Where do you sit on the axes of integration in the diagram at page 7? Is that the right place in the context of your aims?
- Are all the stakeholders clear on the reasons for establishing this particular partnership model?
- Are you clear that the outcomes you are pursuing as a partnership are focussed on service user or patient outcomes and can only be achieved through a partnership approach?