# Chapter 4: Barriers to Partnership Working

## 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

A third of public bodies experience problems in partnerships (Strachan, 2005) and some very high profile partnerships have failed in a messy and public way (Thistlethwaite 2006). Others have found the experience of partnership very painful, progress very slow and occasionally unproductive (Huxham and Vangen, 2004). Huxham and Vangen ask if achievement of *collaborative advantage* is the goal for those who initiate collaborative arrangements, why is *collaborative inertia* so often the outcome?

This chapter reviews the relevant literature and presents the **barriers** to public sector partnership and the potential **unintended consequences** of even successful partnerships.

Writers reflect that not acknowledging barriers to partnership is, in itself, a cause of failure (Rummery and Glendinning, 2000; Lymbery, 2006) and that it is important to recognise the hurdles in advance.

> "It is important to recognise that the very term "partnership" might increasingly be perceived pejoratively, synonymous with lengthy, fruitless meetings, forced upon unwilling organisations by….government policy"

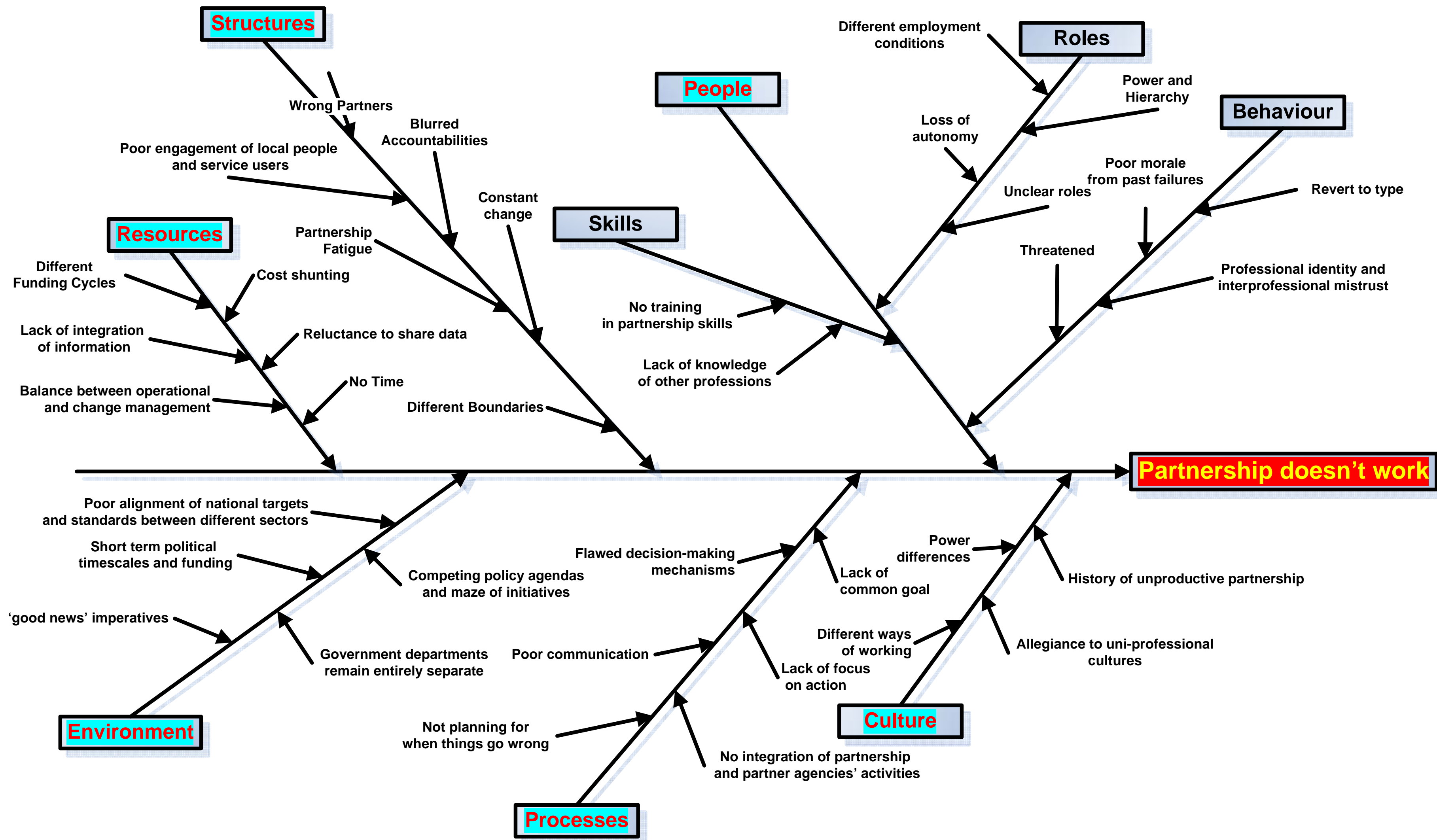
(Armistead and Pettigrew, 2004)

## THE CAUSES AND EFFECTS OF PARTNERSHIP BARRIERS

In analysing the barriers to, and problems with partnership working, many different authors (Keele and Strathclyde, 2006; Wistow and Hardy, 1991; Lloyd and Wait, 2006; Glasby and Lester, 2004) have offered different categories, levels and other means of presenting the issues for partnerships.

This chapter organises the literature review output using a Cause and Effect diagram (see page 4). Also called Ishikawa, fishbone or characteristic diagrams, these represent all the factors that contribute to or affect a given situation. The fishbone diagram seeks to identify root causes, rather than symptoms, and examines the whole system within which the problem arises, allowing remedial action to be focussed on the relevant area of the system. It is an industrial (six sigma) tool which also works well, with some development of the categories, for service sector problem analysis.

## Cause and Effect Diagram of Common Barriers to Partnership



# PEOPLE

## Roles (including power)

Authors found a range of differences around values and roles which served to place barriers in the way of increased integration at team level.

Key themes were:

- **Power and hierarchy in professional and managerial relationships** can stultify effective partnerships. Joint working is difficult where there are perceived status differences between individual participants or occupational groups. Some practitioners perceive threats to their professional status, autonomy and control when asked to participate in more democratic decision making. Dominant, high status professions (often reported as medics) or higher graded officers are perceived to silence others' contributions and risk skewing the outcome of integrative efforts.

  (Glendinning, 2003; Freeman and Peck, 2006; Hudson, 2005; Improvement Network; Lloyd and Wait, 2006; Wistow and Hardy, 1991)

- **Differences in employment conditions** between different organisations can be a barrier to integration, particularly where new patterns of working are being requested at the same time – e.g. 24-hour cover. GPs' independent practitioner status was seen as a barrier by many, which allowed GPs to elect whether or not to join attempts at collaboration.

  (Freeman and Peck, 2006; Leutz, 2005; Rummery and Coleman, 2003)

- The **role of the voluntary and community sector and of service users and carers** is often unclear in partnerships and integrated teams. There is rarely clarity about whether this is expected to be an advocacy, operational, representative or strategic role.

  (Marks, 2007)

## Behaviour

Closely related to issues of power and status in professions covered above, are behavioural barriers to engendering trusting relationships. These include:

- The **professional identity, autonomy and inter-professional mistrust** of any one profession in relation to others limits understanding of other professions. Individual practitioners' lack of knowledge of other professions leads to a tendency to stereotype other workers. Efforts to exchange information about respective roles, if badly handled, can simply reinforce prejudice rather than enlighten multidisciplinary teams.

  (Banks, 2002; Fabbricotti, 2007; Glasby and Lester, 2004; Lymbery, 2006; Rummery and Glendinning, 2000)

- When threatened by organisation change, authors found that **people revert to NHS, local authority or professional type** and that each profession will want the other to change its organisational culture. A variety of behaviours were displayed such as the **"job's worth" syndrome, "power plays",** and other manifestations of **"skilled incompetence"**. In some cases, practitioners deliberately withheld referrals on to other services which could have benefitted the service user/patient.

  (Armistead & Pettigrew, 2004; Edwards, 2007; Kharicha et al, 2005; Thistlethwaite, 2006)

- Managers and practitioners will **reflect in their behaviour what they feel to be a lack of back-up from above** – a lack of commitment from senior managers; non-executive board members or local authority councillors with a poor grasp of the subject area, but who are nevertheless expected to lead change.

  (Glasby and Lester, 2004; Rummery and Glendinning, 2000)

- **Poor staff morale and poor morale from other partners** – particularly service user and community representatives who are unpaid and poorly recognised – will impact on the ability of partnerships to be established and to continue.

  (Armistead & Pettigrew, 2004; Glasby and Lester, 2004; Glasby and Peck, 2005; Maguire and Truscott, 2006

- A **lack of alignment of clinical, financial and managerial perspectives** of the partnership causes barriers in making progress

  (Woodward et al, 2007)

## Skills and Knowledge

Most writers reviewed recorded a **poor understanding of the aims of partnership and a lack of attention given to the development of skills of all individuals involved in partnership** – practitioners; managers; elected and non-executive members; representatives of people who use services; voluntary and community organisations.

## STRUCTURES

> ***'Endless business meetings that no-one wants to attend will result in – guess what? – no-one attending'***
>
> The Improvement Network, *Top 10 partnership killers*

The design of partnership structure can militate against achievement of the aims of the partnership:

- **'Partnership Fatigue'** occurs when agencies are involved in large numbers of partnerships whose purposes are unclear. They will be unable to list partnerships comprehensively or name their fellow collaborators without referring to papers from meetings. New work is frequently grafted onto old partnership structures without reviewing their composition.
- **The wrong (or insufficient) partners are involved** – not looking beyond health and social care, especially to **housing and voluntary agencies**, but also crucially to **users of services and local communities.**
- **Different geographical boundaries** (lack of co-terminosity) will hamper accountability, decision making and budgeting.
- If **no link is made between the work of the partnership and of its member organisations**, it loses ownership and momentum. Partners will set up parallel mechanisms, rather than adapting those that already exist, increasing bureaucracy.
- **A lack of formal structure, accountability and clear roles** and not having a formal partnership agreement will make failure twice as likely.
- Many partnerships are based on **distant and formulaic consultation rather than active engagement.**
- **Continual shifting of organisational structures** disrupts relationships within and across partnerships. Structural change can be an unhelpful distraction, stultifying progress for up to 2 years.

(Audit Commission, 1998; Audit Commission, 2005; Cook et al, 2007; Glasby and Lester, 2004; Glasby and Peck, 2005; Hudson, 2005; Hudson et al., 1998; Huxham & Vangen, 2004; Improvement Network; Lloyd and Wait, 2006; Local Government Information Unit, 2004; SSI/Audit Commission, 2004; Wistow and Waddington, 2006)

## PROCESSES

The way in which partnerships approach the mechanisms of working together can obstruct good partnership.

### Lack of Agreed Outcomes

A general desire to work together is not enough. Absence of agreed outcomes is a common cause of partnership failure and can include the following symptoms:

- **Goals are dominated by service perspectives**, rather than based on outcomes desired by citizens, service users and patients.
- **An agreed partnership vision may be at odds and not integrated with visions of the member organisations**. Partnership activity will be seen as a distraction and possibly threatening to the stability of host organisations
- There can be **outright conflict** or disagreement about the purpose of the partnership;
- Even if **common agreed outcomes can be lost sight of in restructuring, bureaucracy and well-intentioned, but off-beam, new activity** (mission creep) or in 'collusion' - being preoccupied with maintaining good relationships and losing sight of outcomes for local people;
- Where there is no clear goal or end point or agreement about when it has been reached, partnerships can outlive their useful purpose

(Audit Commission, 1998; EIU, 2004; Glasby and Lester, 2004; Glendinning, 2003; Huxham & Vangen, 2004; Improvement Network; Local Government Information Unit, 2004)

### Decision-Making Mechanisms

- Actions will be blocked when members **lack delegated authority** and have to refer to their parent organisations for decisions;
- **Different decision-making processes** in host organisations make getting agreement a cumbersome process;
- Decision-making structures dictated by **dominant partners** and not geared to the needs of all partners, particularly the voluntary and community sectors, will create mistrust and bad decisions.
- Failure to acknowledge the **complexity of achieving change** through public sector partnership (or, conversely, over-complicating analysis of situations) – become an excuse for lack of action.
- A **lack of focussed action** can kill partnership – making it into a talking shop with slow and complex decision-making structures, lengthy, fruitless meetings
- **Not planning in advance for when things go wrong** will leave partnerships ill-prepared to deal with conflict and lead to loss of trust and momentum.

(Armistead & Pettigrew, 2004; Audit Commission, 1998; Improvement Network; Maguire and Truscott, 2006; Marks, 2007; Smith, 1995)

### Poor Communication

- the use of **specialist language** excludes some partners;
- Not supporting members in their communication within communities will result in conflicting messages;
- **communicating selectively** to a few members fuels suspicion and personal agendas.

(Cameron and Macdonald; Improvement Network; Maguire and Truscott, 2006)

## RESOURCES

Resource Barriers can be divided into three areas:

### Money

- **Inappropriate (short term) funding cycles, separate budgets and financial pressures** are some of the most commonly cited barriers to effective partnership working.
- Partners with scarce resources are **reluctant to fund partnership objectives, which may not be their direct responsibility**.
- **Tensions around cost-shifting or 'cost shunting' from one agency to another** are contributed to by concerns over the stability of partners' budgets and the risks of being drawn into financial crises.
- There are **significant costs to partnership working** and, aside from the arguments about who will provide the resources needed to implement decisions, there are also obstacles to overcome in trying to identify **whether the outcomes justify the costs.**

(Audit Commission, 1998; Banks, 2002; Frye and Webb, 2002; Glasby and Lester, 2004; Lloyd and Wait, 2006; Roy and Watts, 2001; Walshe et al, 2007)

### Information

The degree of **integration of information** will pose constraints with:

- **Separate and incompatible IT systems** with no links to communicate across organisations, even where staff are co-located;
- **Reluctance to share data** or develop confidentiality and access protocols;
- Perceived or actual **problems with data accuracy, robustness and timeliness**.
- Problems of aggregating **different versions of the same data**

(Audit Commission, 1998; Effective Interventions Unit, 2003; Improvement Network; Integrated Care Network, 2004; Woodward et al, 2007)

### Time

**Time is the currency which practitioners and managers spend most preciously and is most scarce.** A proliferation of partnerships can make even the most necessary and successful partnerships achieve less than they otherwise could as a result of the critical people on the ground being spread too thinly. There are difficult choices about how to allocate time where it makes most impact:

- **Practitioners are torn between face to face contact and time invested in developing links and connections**, which can be as valuable as the face to face time, but undervalued by many information and performance systems.
- Middle managers have to **fulfil operational roles at the same time as leading change** and developing partnership working.

(Banks, 2002; Frye and Webb, 2002; Kharicha et al, 2004)

## EXTERNAL AND CULTURAL INFLUENCES

Barriers to effective partnership are sometimes caused by external, cultural and political influences:

- **Time sequences** for effective partnership may be longer than political expediency allows. **Short term, ad hoc funding and non recurrent grants** are counter-productive to tackling the sort of **complex and long term problems** that partnerships are required to deal with.
- **'Good news' imperatives** disengage key stakeholders and stifles openness in resolving difficult issues
- The **raft of policies and maze of initiatives** can be difficult – and contradictory – to negotiate.
- Partnership are often **expected to join up services and systems which remain entirely separate at central government level**
- **Poor alignment of targets, performance measures and standards for health and social services** together with separate central performance monitoring and regulation is disintegrative and causes duplication of effort
- **NHS performance** management is found to be still **very acute hospital focussed**; mismatching priorities between health and social care
- **Competing policy agendas**, in particular those forces of *competition and choice* versus *collaboration and integration* are confusing and counter-productive. This is illustrated in the table below:

| Competition and Choice | Collaboration and Integration |
|---|---|
| Short timescale | Longer timescales |
| Mutual benefit | Trust |
| Good news/careful with performance information | Getting to the bottom of a problem/open with performance information |
| Market driven | Values/belief driven |

- A failed partnership can leave a **long-term legacy of mistrust or conflict** between different organisations. It can also leave individuals damaged and compromised in their communities
- Partners come to the table with a **history** of **pre-existing relationships** including, possibly, **misconceptions, suspicion and a lack of trust**. Even in previously successful partnerships, the 'but we've always done it this way' syndrome may impede new approaches.
- Different types of organisation have **ways of working which are often difficult to combine**. They come to the table with their **own set of attitudes, experiences, beliefs and values** – the organisation culture. In public, private, voluntary and community sector health and social care partnerships, culture comes not only from constituent organisations but also from the different professional groups.

(Armistead & Pettigrew, 2004; Audit Commission, 1998; Banks, 2002; Caines, 1999; Coe, 2002; Cook et al, 2007; Edwards and Miller, 2003; Effective Interventions Unit, 2003; Glasby and Lester, 2004; Glendinning, 2003; Holtom, 2001; Home Office, 2007; Hudson, 2005; Hultberg et al, 2005; Kharicha et al, 2005; Local Government Information Unit, 2004; Marks, 2007; NAO, 2001)

## UNINTENDED CONSEQUENCES

Finally, a few words about the implications for other parts of the system of even the most successful partnership. **It is not possible to make a change in one place without impacting elsewhere in such a complex system**. Partnerships need to understand and manage the consequences of improved integration and service outcomes in one part of a system upon others.

**Integrated services must have boundaries at some point** and some of the common problems of partnership relate to the risk of **creating tensions at the new interfaces** in the following areas:

- Relationships with specialist services;
- Linkage to generic community or locality based strategies by care programme-specific partnerships
- Fragmentation of mono-professional networks
- 'Your integration is my fragmentation' (Leutz, 2005). Generalists (particularly GPs) get pulled in different directions by integration of different care programmes and can experience it as fragmentation of their jobs.

(Edwards and Miller, 2003; Fabbricotti, 2007; Glasby and Lester, 2004; Kharicha et al, 2004)

## CONCLUSION

The factors outlined above will occur in more or less degrees in many types and levels of partnership. The first defence against them is knowledge – and open acknowledgment within the partnership – of their existence. Thereafter, partnerships will need to identify those factors which they can and cannot control and take action on aspects within their power.

Armistead and Pettigrew (2004) described “partnership viruses”, which may be caught from founding members who unwittingly carry poor practice and poor skills into partnership, or from new members or via environmental influences external to the partnership. Those working in partnerships should be on the look out for viruses and vigilant in maintaining a “healthy life style” to minimise the chances of contracting the virus.

The strong advice from most writers is unless there is no other way of tackling a problem or achieving your goals than through multiple agencies; don’t. It is time consuming, difficult and expensive. Reduce the number of partnerships you are involved in and apply the best principles of openness, clarity of purpose, active organisation development and adequate resourcing to the few very important partnerships without which you can achieve nothing alone.

## REVIEW QUESTIONS

- Think of the partnership in which you are involved or trying to establish.
- Does the goal you are trying to pursue *really* require a partnership approach? If not, do it another, easier way
- Circle the specific problems (small black text) you are encountering in the fishbone diagram
- Look to see where the majority of your problems seem to lie – culture, people, process, structure, resources or environment?
- Tackle the most pressing areas first. Use Chapter 5 of these Briefing Notes – Characteristics of Successful Partnerships - to tackle barriers
- Don’t try to tackle things over which you have no control, but acknowledge and live with them – just identifying and talking openly about them within your partnership will help