Partnerships and Networks: Past Lessons from Health and Social Care

Briefing Note 1

June 2006

Jane Mackinnon
Moira Fischbacher
Judy Pate
Phil Beaumont

School of Business & Management
University of Glasgow

This briefing note has been produced as an initial report from the Glasgow Centre for Population Health funded project "Managing Partnerships for Health Improvement"[1]

[1] Further information on this project is available from Jane Mackinnon, School of Business and Management, University of Glasgow, Email J.Mackinnon@mgt.gla.ac.uk.

Abstract
The paper draws on important lessons learnt from evaluation of partnerships between health and social services in Managed Clinical Networks and Health Action Zones that are likely to have implications for the development of Community Health Partnerships (CHPs) in Scotland. For example, issues highlighted have included the need for a clear vision, clarity of strategic focus, effective two-way communications, honesty and trust between partners, adequate resources for building collaborative capacity, and building on learning from previous partnerships. Each of these issues are examined briefly to outline the potential for building best practice for partnership working. The paper concludes by outlining the plans for a GCPH-funded study of managing partnerships in Glasgow, which aims to both contribute to and learn from the unique experience in Glasgow of integrating health and social services in CHCPs.

Introduction
This paper aims to provide a brief overview of key lessons learned from two existing networks and partnerships in health and social services, Managed Clinical Networks and Health Action Zones. It begins by highlighting policy developments relevant for establishing partnerships and networks as ways of working and as vehicles for promoting health improvement and tackling health inequalities in Scotland.

The Scottish Health Improvement Policy Scene
During recent years tackling inequalities and improving health have become growing priorities for the Scottish Executive[(1, 2)]. The white paper *Towards a Healthier Scotland* recognised the impact of life circumstances on health and the relationship with health inequalities and highlighted the need for public health policies to tackle these wider determinants of health[(2)]. In 2002, with the release of their spending proposals[(3)] and *Closing the Opportunity Gap*[(4)] the Scottish Executive demonstrated the high priority they placed on tackling inequalities across all aspects of society, and acknowledged the links between the root causes of inequalities and the subsequent impact on the health and well-being of the population.

As policies have developed, partnerships as a means of addressing inequalities and improving population health have become the preferred organisational model. Since then, the integration of health care and related services has been a growing priority for the NHS and Social Services. The 2003 white paper on health, *"Partnership for Care"*[(5)] highlights the value of partnership working in the delivery of services to the population, and outlines the Government's commitment to improving partnership working. Furthermore, *"Improving Health in Scotland: The Challenge"*[(6)] emphasises the importance of partnership working at all levels as a vehicle for successful health promotion.

Subsequent policy has been directed towards creating collaborative, inter-agency, planning processes and organisational structures that reinforce a local planning perspective with locally sensitive solutions, whilst taking an overall population perspective on tackling health inequalities. The primary organisational means for achieving these objectives and addressing the Scottish Executive's priorities has been the creation of Community Health Partnerships (CHPs). Initially introduced in *Partnership for Care*[(5)], and reaffirmed in the *Partnership Agreement*[(7)], they represent a very specific investment and belief in the value and contribution of inter-agency partnerships as a means of achieving health improvement.

"It is intended that CHPs will create better results for the communities they serve by being aligned with local authority counterparts and by playing an effective role in planning and delivering local services."

Partnerships for Care (2003).

In 2004 all Health Boards were placed under a duty to establish either a CHP for the area of the Health Board, or two or more CHPs for districts that include the whole area of the Health Board[8]. Underpinned by the Local Government in Scotland Act (2003)[9], Local Authorities are expected to lead collaborative Community Planning processes within the CHP structures. They, along with NHS and other agencies within the partnerships, are also to ensure that the health improving potential of Community Plans, Social Inclusion Partnership, Healthy Living Centres and other community-based initiatives are optimised[6]. In addition to these inter-agency partnerships, the NHS, Local Authorities and community and voluntary sectors are expected to work together to implement approaches which engage patients and community members in health improvement under the CHP umbrella.

Full details of the national aims and objectives of CHPs can be found in the CHP Statutory Guidance[8]. A summary of the key aims presented in *Partnership for Care*[5] state that CHPs would:

- ensure patients, carers and the full range of health care professionals are involved;
- establish a substantive partnership with local authority services (e g social work, housing, education and regeneration);
- have greater responsibility and influence in the deployment of Health Board resources;
- play a central role in service redesign locally;
- focus on integrating primary and specialist health services at local level; and
- play a pivotal role in delivering health improvement for their local communities.

These aims are adapted for each CHP, and local objectives and priorities are set out in the individual Schemes of Establishment (http://www.show.scot.nhs.uk/sehd/chp/).

More recently *Building a Health Service Fit for the Future* (2005) emphasised the important role for CHPs[10]:

> *"Community Health Partnerships (CHPs) offer the potential for a fresh exploration of partnership working and a channel through which services can be better co-ordinated and delivered, depending on local circumstances and decisions"*. (p56)

Although this, and subsequent national reports, do underline the importance of working in partnership to improve the integration of health and social care, greater emphasis has been placed on the links between primary and secondary care. However, some areas, such as Glasgow City, have developed a model which places greater emphasis on the integration of the NHS and the City Council social work services[11]. This has been done in an effort to drive forward a joint NHS and social work agenda for the improvement of population health and well-being. The Glasgow City Scheme of Establishment sets out the proposal to establish five Community Health & Care Partnerships (CHCPs). The CHCPs will bring together NHS and Local Authority responsibilities with the aim of maximising the ability to improve outcomes for service users. Initial priorities for the

development of the CHCPs further highlight the integration of health and social care services, including a clear programme to tackle health and social inequalities; continued implementation of the new Practice Team model of Social Care Services and realising the gains for service users of fully integrated local services[11].

An important aspect of CHPs, and in particular CHCPs, is the increasing move towards integrated health and social policy for improved service delivery; and through the development of joint targets for health and wellbeing and health inequalities.

For the remainder of this paper where CHPs are discussed this includes CHCPs.

Lessons From Partnerships in the UK

Partnership for Care[5] acknowledged the need to build on existing success. We have selected two types of partnership as illustrative examples to highlight key issues associated with partnership. These are Managed Clinical Networks (MCNs), primarily the South East Scotland Cancer Care MCN (SCAN), and Health Action Zones (HAZs). The two case studies were chosen as they both aimed to develop effective partnerships that would enable integration of service delivery, improve the quality of services, and ultimately to improve the health of their target population. Together these two models provide some useful learning across the social care and health sectors, along with many other cross-sector partner agencies. Both have also been the subject of formal evaluations from which we can draw lessons.

MCNs are defined as *"linked groups of health professionals and organisations from primary, secondary and tertiary care working in a co-ordinated manner, unconstrained by existing professional and organisational boundaries to ensure equitable provision of high quality effective services"*[12]. The role of MCNs for integrating services both within the NHS and across boundaries between the NHS and local authority services has recently been emphasised further[10].

The HAZ initiative delivered in England, was the first area-based initiative implemented by the Labour Government in 1997. It was developed to improve health and reduce health inequalities in twenty-six of the most deprived communities across England. HAZs were to develop as multi-agency partnerships and were encouraged from an early stage to provide local solutions to local problems[13].

It is not within the scope of this paper to cover all learning from these partnerships. Instead, this paper is intended as a brief introduction to some important lessons considered relevant for collaboration within CHPs. Details of the HAZ and MCN evaluation sources, along with a small number of further useful sources for those interested in reading more about partnerships and networks in the health and social care sectors, are provided at the end of this paper.

Strategic Focus
A shared vision and clear strategic focus have been identified as key to partnership success, as illustrated by the evaluations of HAZs and SCAN. SCAN members felt that a shared views and understanding of the purpose of the networks contributed to collaborative working[14]. It was evident in the evaluation of HAZs that the level of strategic focus and clarity of approach was clearly linked to the strength of

partnerships[15]. Where strong partnerships existed they helped to maintain a level of cohesion enabling the HAZ to move forward, and became a means of sustaining partnerships. In some HAZs a clear strategic focus from the start was maintained throughout. Consequently, these areas reported confidence and optimism that the learning and work of the HAZ would be carried forward by new structures and organisations. The strength of leadership and a high degree of ownership amongst partners was perceived to have contributed to this clarity of focus.

In relation to developing a strategy aimed at tackling health inequalities, the HAZ evaluation concluded that clearer definitions of health inequalities locally would help to provide greater strategic focus to local goals[13]. It was acknowledged that significant effort is necessary to develop a shared understanding and ownership of the health inequalities agenda and goals, so that all relevant players are able to contribute meaningfully to strategic development and implementation.

Leadership

Leadership can have a significant impact on a partnership. For instance, SCAN members identified good leadership as crucial in pulling people together, stating that individual personalities were important to the success of the group and that it was important to demonstrate respect and diplomacy[14]. Similarly, the HAZ evaluation found the strength, direction and cohesion of the partnership and its subsequent perceived impact was related to the strength and stability of leadership.

Powerful leadership within HAZs came from different levels of the partnerships. Where crosscutting issues were seen as being owned at a senior level, this sent out powerful messages through the whole organisation[15]. This was crucial in an initiative such as HAZ where a wide range of partners were involved. Methods of achieving this included appointing a joint chair on a steering group, held by a former Health Authority Chief Executive and a Local Authority Chief Executive. This gave the HAZ joint ownership at the highest level and this message and way of working was then filtered down into the partner organisations.

Individuals known as 'HAZ champions' were also found to play a key role in the collaborative process within partnerships and organisations[15]. These individuals were not only seen at a senior level, but an operational level too, for instance as project managers and coordinators for the initiative, and were viewed by steering group members as being crucial in developing a level of cohesion and crucial connections across the HAZ.

Communication

Effective communication was highlighted as being vital to both HAZs and SCAN. The HAZ evaluation found that developing effective modes of communication was an important factor associated with building ownership. The evaluation of SCAN found most respondents believed the network to be good at communicating, and they felt well informed[14]. However, some felt the lines of communication were too one-way with not enough information coming out from the central group, and some less active members of the network felt they did not receive enough information. The evaluation recommended that the network should consider widening its communication to include those working in cancer but who are not active members of the network.

Good communication was also seen as key to awareness raising about the purpose and work of the HAZ and MCN. The SCAN evaluation concluded that awareness-raising would allow opportunities for staff to explore how working with MCNs affects their own

roles and responsibilities within the network, and this could help staff to understand how they may contribute to its development[14].

Trust

Trust is an important element of collaborative working and can be crucial to the success and sustainability of many partnerships. For HAZ staff the ability to demonstrate their competence to other stakeholders was key to building trust. The management of perceived risk can also act as an important motivating factor in driving partnership working. It was through such acts within partnership arrangements that a high level of trust developed in some HAZs[15].

The absence of trust in some HAZs was cited in circumstances where individuals found themselves in unfamiliar partnerships with people and organisations they had little experience of[15]. Some HAZs found the introduction of certain 'ground rules' for collaboration helpful and important in overcoming some of these challenges[16]. Formal codes of conduct were developed early on in complex HAZs where there had been little prior collaboration. These agreements were said to help 'prevent misunderstandings' and help meetings run more smoothly. This was also evident amongst partners who had worked together previously and considered themselves skilled at collaboration[16].

For trust to develop and grow it is necessary for partners to be honest with colleagues about the reason for being involved in a collaboration. For instance SCAN members were involved for a range of reasons including progression of jobs, some were invited due to their position, and some to influence services and strategy[14]. Within some HAZs, those individuals who were most positive about the HAZ and their contribution to it were those for whom HAZ had provided an important opportunity to shine in career terms as well as offering a framework for action based on principles which they shared[15].

Collaborative Capacity

Building the capacity of the partners to engage is fundamental to collaborative activity at all levels, from grass-roots community groups through to statutory organisations needing to develop better understanding of the different cultures and priorities of prospective partners. It is also crucial to recognise that strong partnerships take time to develop. The HAZ evaluation supported the view that capacity building is needed at a number of levels[16], as displayed in Box 1.

Box 1: Building Collaborative Capacity in HAZs

- Strategic – acting collectively to establish a vision and to institute appropriate partnership bodies;
- Governance – developing ways of securing an appropriate constitutional form and accountability arrangements to enable good governance of collaborative action;
- Operational – the way in which partners make use of mechanisms to maximise the collaborative effort in order to deliver new types of service arrangements;
- Practice – the skills and abilities of workers and their capacity to embrace and further the collaborative agenda;
- Community – the capacity of communities and citizens to engage with and take part in the opportunities opened up by HAZ;
- Voluntary sector – enabling voluntary sector agencies to become equal partners in achieving shared outcomes and building the infrastructure that can support this.

The HAZ evaluation supported the view that long-term complex collaborations require adequate resource support to sustain the partnerships that develop(16). Without this there is a danger of relying on the existing capacities of committed individuals and there is less chance for development of the *organisational* capacity necessary to sustain collaboration(16). The evaluation also identified the need to appreciate that different sectors work to different timescales, and have different cultures and ways of working. These perspectives need to be considered in the development of collaborative strategies.

Power relations are crucial in collaboration. Within HAZs, the experience of developing infrastructure support for voluntary agencies to increase their capacity to play a significant role in collaborative governance was mixed. But although respondents felt that the HAZ experience had legitimised their role in local governance beyond that of service delivery agents there was little evidence that voluntary sector groups felt that they became equal partners in the HAZ enterprise(16). However, the evaluation also concluded that not all stakeholders need to be involved equally at all levels but they must be involved at the levels and sites that will have most significance for them. Within SCAN, some members viewed the networks as becoming less hierarchical and found that they were more equal partners; however, some felt the decisions were still made by medics and surgeons in particular(14).

Specific issues relating to the capacity of communities and patients to become involved in a partnership were also identified by the HAZ and SCAN evaluations. Views on the impact of the SCAN networks in relation to increasing patients' influence on cancer strategy and services were mixed. There was some feeling of influence, although some held reservations over the nature of involvement and the possible motives of those involved. HAZs found that communities needed support in developing skills and confidence before they could become active partners, and this took time and resources(16). A further important factor acknowledged in the early stages of the HAZ evaluation difficulties with traditional consultative exercises as a way of 'engaging' communities(13).

Learning in Partnerships

Although it is difficult to attribute success to a specific initiative or partnership, the need for a culture of evaluation and learning are acknowledged in health and social care, as evidenced in the HAZ evaluation. It is important to 'mainstream' learning from previous partnerships and collaborative endeavours, for instance, mainstreaming good practice or ways of working.

Implications for CHPs

It is essential that CHPs build upon those partnerships and relationships that already exist, and learn from those that have been both more and less effective in the past. It is clear that there is a range of important learning opportunities that CHPs can draw from. This brief paper has highlighted some of these, and their implications for CHPs are summarised below:

- CHPs will require clarity when developing a strategy for the partnership in order to maximise potential for cohesion and sustainability. Shared understanding of key definitions, such as inequalities in health, will also be key when working across differing organisational cultures.

- Leadership of the CHP as a whole and of different groups within the partnership will be crucial to maintain cohesion and stability with the new partnership arrangements. 'CHP champions' could be key figures to assist this process at all levels of the partnership and across a wide range of professional areas.
- Communication in a partnership as large as the CHP will also be vital, especially as it is bringing together different organisations. Clear communication of developments and progress can keep staff well informed. However, care is needed not to overload staff with information they may consider has less relevance to their own day to day jobs.
- Building and maintaining trust will be crucial to the development of CHPs, in particular where new working relationships are being formed across organisations and professional groups. Where trust has developed through existing working relationships, this should be acknowledged and utilised to assist this new partnership development.
- Taking some time to build collaborative capacity at all levels (see box 1) will enable *organisational* capacity to develop across all partners in the CHPs. In turn this will contribute to the sustainability of collaborative efforts by reducing dependence on a small number of people. In doing so, respect should be paid to the differing cultures and ways of working within partner organisations.
- CHPs are required to develop a formal dialogue with their local communities through the development of a local public partnership forum (PPF), and other existing channels. It will be crucial to build on knowledge, expertise and capacity that already exist through organisations such as local community health projects and pre-existing patient and public involvement forums. For instance, individuals working in these organisations will be able to guide the CHP in how to effectively engage with local communities in a meaningful way, and will be an important resource to the new partnerships.

Building on Partnership Practice

The preceding sections have identified some lessons that can be drawn from partnership experience to date. The findings from the evaluations have resonance with a broader body of research from social policy, economics and management where projects have consistently identified considerable benefits from partnership initiatives as well as considerable challenges to organisational structures, processes and cultures. Whilst the broader literature (which we will deal with in subsequent publications) frequently discusses characteristics of 'successful' partnerships and collaboration, much less is known about how the collaborative process enables partnerships to accomplish more than individuals and organisations on their own in terms of organisational performance or broader changes in populations. It is this gap which has informed the development of our current research.

The population perspective

Making the connection between collaborations and the impact on the health of communities is problematic for a number of reasons. For instance, changes in population health outcomes can take years to become visible, and are often difficult to attribute to specific interventions or processes. Earlier studies have found insufficient evidence to make strong conclusions about the effect of partnerships on population-level outcomes[17]. Difficulties include the lack of appropriate available measures and insufficient baseline and follow-up data. Impact might also be masked by secular trends that are demonstrating population-level health improvement.

Although this research project will not directly explore the links between the newly emerging partnerships and population level data, it will explore how this might be achieved.

The Organisational Perspective: Outline of plan for the "Managing Partnerships for Health Improvement" research study

A primary set of considerations for the research study arise at a partnership level in considering the beneficial impact (or otherwise) of partnering as a means of improving organisational performance. As noted above, there is a wealth of literature on the potential benefits of partnerships and networks, and on the processes involved in partnering. What is less well understood are the indicators of success, or appropriate measures of organizational performance. In the case of current health and social policy, ultimately CHPs can only really be considered a 'success' if they contribute to improved services and improved health. It becomes important therefore for the research team to consider:

- the management of inter-agency networks eg, how can their effectiveness be measured?
- how best to balance local interests (and adaptability of services) with the need for strategy across an area and enough similarities to compare CHPs in terms of their effectiveness and best practice;
- the nature and development of trust between individuals and agencies involved in CHPs, ways of developing a common language and understanding different organisational cultures and working practices;
- the 'balancing act' between spending time and energy developing trust and good working relationships versus concentrating on service delivery and 'getting on with the job'; and
- how the success of CHPs can be measured, if indeed it can be within the timescales of this research. Given improvements in population health cannot readily be detected in the short term, what proxy measures might there be that would be indicators of success in the short and longer term?

The study began in October 2005 and will report in September 2007, with interim papers and feedback to participants at relevant points throughout the two years.

Concluding Remarks

This briefing note has identified some of the lessons learnt from the health and social care sector partnerships. The "Managing Partnerships for Health Improvement" project aims to address a number of the points raised in the latter parts of this briefing note within the context of CHCP development in Glasgow. Further information about the project can be obtained from either Moira Fischbacher or Jane Mackinnon (University of Glasgow, School of Business & Management), or from Pauline Craig at the Glasgow Centre for Population Health.

References

1. Scottish Office (1997) *Designed to Care – Renewing the NHS in Scotland,* The Stationary Office, Edinburgh.
2. Scottish Executive (1999) *Towards a Healthier Scotland*, The Stationary Office, Edinburgh.
3. Scottish Executive (2002) *Building a Better Scotland. Spending Proposals 2003-2006: What the money buys,* Scottish Executive, Edinburgh.
4. Scottish Executive (2002) *Closing the Opportunity Gap. Scottish Budget for 2003-2006,* Scottish Executive, Edinburgh.
5. Scottish Executive (2003) *Partnership for Care*, The Stationary Office, Edinburgh.
6. Scottish Executive (2003) *Improving Health in Scotland: The Challenge*, The Stationary Office, Edinburgh.
7. Scottish Executive (2003b) *A Partnership for a Better Scotland: Partnership Agreement*. Scottish Executive, Edinburgh.
8. Scottish Executive Health Department (2004) *Community Health Partnerships Statutory Guidance,* Scottish Executive, Edinburgh.
9. Scottish Executive (2004) The Local Government in Scotland Act 2003: Power to Advance Wellbeing Guidance. Scottish Executive, Edinburgh.
10. NHS Scotland (2005) *Building a Health Service Fit for the Future. A National Framework for Service Change in the NHS in Scotland*, Scottish Executive, Edinburgh.
11. Greater Glasgow NHS Board and Glasgow City Council (2005) *Glasgow City CHSCP Scheme of Establishment,* Glasgow.
12. Scottish Office Department of Health. Acute services review report 1998. 1998. Edinburgh, Stationary Office. 1998.
13. Barnes M, Bauld L, Benzeval M, Judge K, Lawson L, Mackenzie M, Mackinnon J, Matka E, Meth F, Sullivan H, Truman J (2003) *National Evaluation of Health Action Zones. A final report.* Report to the Department of Health, London.
14. Livingston M, Woods K (2003) *Evaluation of South East Scotland Cancer Network. Feedback Paper 3.* University of Glasgow.
15. Mackenzie M, Lawson L, Mackinnon J, Meth F, Truman J (2003) *The Integrated Case Studies: A Move Towards Whole Systems Change?* Department of Health, London.
16. Barnes M Sullivan H, Matka E (2003) *The Development of Collaborative Capacity in Health Action Zones. A final report from the national evaluation.* University of Birmingham.
17. Mackinnon J, Reid M, Kearns A (2006) Communities and Health Improvement: a review of evidence and approaches, Report for NHS Health Scotland.

Additional Reading

In addition to the reference list, readers may find the following sources to be useful in providing greater discussion around key aspects of working in partnership in the social care and health sectors.

- Barnes M, Bauld L, Benzeval M, *et al.* (eds) *(2005) Health Action Zones: Partnerships for Health Equity*. Routledge, London.
- Hudson B, Hardy B (2002) 'What is a successful partnership and how can it be measured?' in Glendinning C, Powell M, Rummary K (eds) *Partnerships, New Labour and the Governance of Welfare*. Policy Press: Bristol.
- Huxham C, Vangen S (2005) *Managing to Collaborate. The theory and practice of collaborative advantage.* Routledge, Oxon.

- Ridley J, Jones L (2001) *User and Public Involvement in Health Services: a Literature Review, Partners in Change.* NHS Health Scotland & Scottish Executive.
- Roussos S T, Fawcett S B (2000) A review of collaborative partnerships as a strategy for improving community health. *Annual Review of Public Health*, 21: 369-402.
- Voluntary Health Scotland (2003) *Partnership Development Initiative. End of Year Report*. Voluntary Health Scotland, Edinburgh.