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**Frontline perspectives on “joined-up” working relationships: A qualitative study of social prescribing in the West of Scotland**

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## **Conflicts of Interest**

None

## **ABSTRACT**

Cross-sector collaboration has been promoted by government policies in the United Kingdom and many western welfare states for decades. Literature on joint working has focused predominantly on the strategic level, neglecting the role of individual practitioners in putting 'joined-up working' into practice.

This paper takes the case of 'social prescribing' in the West of Scotland as an instance of joined-up working, in which primary healthcare professionals are encouraged to refer patients to non-medical sources of support in the third sector. This study draws on social capital theory to analyse the quality of the relationships between primary healthcare professionals and third sector practitioners.

Eighteen health professionals and 15 representatives of third sector organisations participated in a qualitative interview study. Significant barriers to collaborative working were evident. The two stakeholder groups expressed different understandings of health, with few primary healthcare professionals considering non-medical sources of support to be useful or relevant. Health professionals were mistrustful of unknown third sector organisations, and concerned about their accountability for referrals that were not

successful or positive for the patient. Third sector practitioners sought to build trust through face-to-face interactions with health professionals. However, primary healthcare professionals and third sector practitioners were not connected in effective networks.

We highlight the on-going imbalance of power between primary healthcare professionals and third sector organisations. Strategic collaborations should be complemented by efforts to build shared understandings, trust and connections between the diverse frontline workers whose mutual co-operation is necessary to achieve effective joined-up working.

### **Keywords**

Collaborative working; partnership; third sector; primary healthcare; social capital; social prescribing

### **What is known about this topic**

- Collaborative working is advocated to tackle complex public health issues
- Effective social prescribing depends on communication and collaborative working

### **What this paper adds**

- Primary healthcare professionals and third sector practitioners did not share understandings about their respective roles and expressed mistrust in the other stakeholder group
- Power imbalances between primary healthcare professionals and third sector workers were evident
- Efforts to develop shared understandings, trust and connections between grass-root practitioners in different sectors are recommended for effective collaborative working.

## INTRODUCTION

Concerns that government departments have traditionally acted as 'silos', which fail to address the multiple causes of complex public health needs, have fuelled a policy interest in 'joined-up working', 'partnerships' and 'collaborative working' across public, private and third sectors (Irvine et al. 2002, Cameron et al. 2011, Dhillon 2009). In policy, practice and research, collaborative working has been predominantly considered at the inter-organisational level (Lindsay et al. 2012). Policies call for the establishment of structures to enable strategic level actors to communicate across sectors and administrative procedures. Research on the factors undermining joint working has focused on inter-organisational issues, particularly power imbalances. However, little attention has been paid to the frontline staff who are expected to work together (Lindsay et al. 2012, Aveling et al. 2014). No matter how reasonable a policy, or how well-designed a structure, ultimately, 'collaborative working' in primary healthcare is actualised in the relationships between doctors, nurses, social workers, practitioners working in third sector organisations, community activists, and many others. As each group has different life experiences, understandings, knowledge, and interests, collaboration among them cannot be assumed to be simple (Aveling et al. 2014, Popay et al. 2007).

The current paper contributes an empirical study of frontline workers' experiences of 'social prescribing' as a case study of collaborative working between primary healthcare services and the third sector in the West of Scotland. By investigating how joint working is experienced by frontline staff, the barriers and opportunities, which may need to be addressed for effective collaboration, are explored. This paper reports on one element of a wider study that formed the basis of the lead author's PhD thesis.

## **Social Prescribing**

Social prescribing is a way to link people with community-based sources of support which are provided outwith traditional statutory health services (in the context of this paper, the UK's National Health Service). It is a relatively recent term for an approach that has become increasingly mainstream since the early 2000s. Social prescribing schemes aim to provide an integrated pathway for referring patients, with social, emotional and/or practical problems, from primary care services to non-clinical services provided in the community, often by third sector organisations (Thorlbury 2013, Brandling et al. 2007). From a policy perspective, it is mainly promoted as an alternative care pathway to help people with mild to moderate mental health symptoms (Scottish Government 2012) and as a way to help people manage long term medical conditions (Coulter et al. 2013, Mossabir et al. 2015).

Social prescribing is underpinned by a social model of health, which recognises that common mental health problems are often psychological manifestations of social problems. Non-medical interventions are thought to offer social and individual solutions by increasing social contact and improving access to services (South et al. 2008). Advocates of social prescribing suggest that by facilitating people's participation in community-based activities, protective factors for mental health will be strengthened (Barry et al. 2009).

The term 'social prescribing' has brought together an assortment of activities and service delivery models. The most common examples are schemes that refer people directly from primary care to initiatives such as 'exercise-on-referral/prescription'. An alternative approach is 'linking schemes' where people are referred to a 'link' worker who then facilitates access to non-medical sources of support (Mossabir et al. 2015). Less formally, a health professional might suggest or 'signpost' a community-based service or organisation

to a patient, for example, recommending they contact a self-help group. Many of these 'non-medical' activities are provided by groups and organisations in the third sector.

### **Conceptualising working relationships in social capital terms**

Theoretically, we draw on the concept of social capital to unpack the relationships through which collaborative working is played out. Social capital is understood as the "resources embedded in social relations and social structure" (Lin 2001), p.24). It is the 'glue' that ties people together into communities and that forms bridges between communities (Poortinga 2006). The concept has been widely used to understand health inequalities, social exclusion and regeneration (Wakefield et al. 2005). However, in this study, we use the concept in a narrower, more specific sense, to understand the quality of the relationships between primary healthcare professionals and third sector workers.

In particular, we draw on the work of (DiCicco-Bloom et al. 2007), who outline a framework describing the main dimensions of social capital, namely, cognitive, relational and structural social capital (Figure 1). Within this theoretical framework, each dimension consists of different attributes. Cognitive social capital refers to shared understandings, values and beliefs. The development of links between individuals, individuals and groups, and groups and organisations is dependent on a certain degree of shared understandings between them (Wakefield et al. 2005). Relational social capital is represented by the characteristics of relationships such as trust and co-operation. Individuals who trust each other are more likely to work together in a co-operative manner (Casey, 2008). Structural social capital describes the pattern of social connections between individuals, individuals and groups, and groups and organisations (Baum et al. 2003), which encourage the development of shared understandings and trusting relationships (Silk 2008).

The dimensions are inter-related; cognitive and relational attributes, such as shared understandings and trust, help shape the structure of networks. Equally, the presence of networks creates and reinforces the cognitive and relational aspects of social capital (Ferlander 2007).

The successful functioning of social prescribing depends upon effective communication and collaboration between primary healthcare professionals and third sector workers (Brandling et al. 2007). Relationships are likely to be stronger, the more partners share understandings, trust each other, and have dense network ties. Therefore, we used this framework to investigate the relationships between the two participant groups, by considering their understandings, mutual trust and network ties.

### **Figure 1:**

#### **Study Aim**

This study examines factors that may promote or compromise the implementation of social prescribing, as a collaboration between statutory and third sectors in Scotland. Informed by the tripartite social capital framework, it asks the following three questions:

- To what extent are the actors' understandings of their own role and the role of the other group shared?
- What are the actors' perceptions of their relationship?
- Are the actors connected in effective relationships?

#### **METHOD**

##### **Research design**

A qualitative interview study was undertaken in one NHS Health Board area in West Central Scotland. Semi-structured interviews were conducted with a sample of NHS primary



healthcare professionals ('prescribers'), and representatives from three community organisations ('providers'), offering activities that could be 'prescribed' by NHS health professionals.

### **Study setting**

The geographical area of the NHS health board area had a population of around 374,000 living in a mix of rural and urban locations. Approximately 20% of the population lived in an area categorised as being within the 15% most deprived areas of Scotland as measured by the Scottish Index of Multiple Deprivation (Hooke et al. 2013).

Three community organisations were selected purposively to take account of contextual factors such as different funding sources or size:

- (a) The lifestyle project offered guidance and support to adopt a healthy lifestyle. NHS health professionals were able to refer individuals to a 'lifestyle referral' scheme. An individual programme of physical activity and dietary advice was offered.
- (b) The carers' centre offered information, advice and support to unpaid carers. Carers could be referred by professionals in health or social services. The centre offered practical and psychological support on an individual or group basis.
- (c) The community health project aimed to holistically support the health and wellbeing of people living in the neighbourhood. At the time of this study, the focus was on the development of programmes to address mental health issues including substance misuse.

### **Data collection and analysis**

Semi-structured interviews were carried out by the lead author using a topic guide which was developed on the basis of a review of available literature as well as expert opinion (Brod et al. 2009). The topic guide was used in a flexible manner, allowing some

area to be discussed in greater depth, depending on the relevance for the participant. The interviews were recorded, transcribed verbatim and imported into the qualitative data analysis program QSR NVivo 9. A thematic analysis was conducted, to extract the themes underlying each group's understanding of their own role and the role of the other group in the process of social prescribing, along with their views of their relationship and connections. An inductive approach, in that themes emerged from participants' accounts, was taken. The emergent themes, which are explored in the findings section, were discussed and reviewed by the co-authors. A reflexive account of how the lead author may have affected the data was kept to help ensure a rigorous research process. Data collection and analysis was carried out between 2009 and 2010.

### **Ethics**

Informed consent, which included permission to use the information collected, along with anonymous quotes, in research reports and publications, was obtained from participants prior to interview. Information about the study was sent to participants in advance. Personal details about each participant were kept confidentially. Any identifiable personal information in the audio-recordings was removed during transcription. This study was reviewed and approved by the local NHS Research Ethics Committee (08/S0202/21).

### **FINDINGS**

In this section, after a brief description of the participants, the prescribers' and providers' views are presented separately. Comparisons between each group's perspectives will be explored in the discussion.

### **Participants**

Community nurses and general practitioners were recruited as potential 'social prescribers'. Each group was sampled purposively to take account of the geographical

location of their workplace and to ensure that there were participants from each professional discipline (health visiting, district nursing and general practitioners) working in a mix of urban and rural locations. Seven health visitors, eight district nurses and three doctors agreed to take part. The general practitioners were offered a standard rate of recompense for their time. Fifteen practitioners from the case study organisations (six from the lifestyle project, four from the carers' centre and five from the community health project), occupying a range of operational and strategic positions, volunteered to be interviewed. The profile of participants is summarised in Table 1.

**Table 1:**

### **Prescribers' perspectives**

We identified three main themes. The first explores how the prescribers described their own role in relation to improving health in general, in the process of social prescribing in particular, along with their views of the role of the other stakeholder group. The second captures prescribers' concerns that they may be held accountable for the actions of unverified organisations. The last theme describes the prescribers' limited awareness of the case study projects.

### ***Identifying a need***

Social prescribing requires a health professional in primary healthcare to recognise that an individual has a problem that could be addressed by making contact with a non-medical source of support. Prescribers described their role in terms of identifying a need and suggesting a solution:

“my role is, I'm identifying what she needs and I can provide that through another agency, not entirely through me...if you identify that someone has a

financial problem...I don't have the skills or perhaps the full knowledge to solve that, so I would refer to welfare benefits [advice service]" *[Health visitor 1]*.

Health visitors discussed their role in terms that extended beyond the care of an individual. They believed that family and social circumstances influenced an individual's health and ability to follow a healthy lifestyle:

"there's so many other impacts on these women's lives at that time *[pregnancy]*...issues round about homelessness...abusive partners, poverty" *[Health visitor 2]*.

Making suggestions about or referring to alternative sources of support was considered to be part of their everyday role. If advice or support was beyond their field of expertise or time available, an alternative source of help would be suggested. However, rather than replacing their input, social prescribing activities were felt to be undertaken in conjunction with their own involvement:

"*[name]* is...a voluntary agency, where volunteers will work with mum, a bit of practical support...that volunteer could be...helping her to get into a routine for example...I would still visit and make sure that that service was appropriate, that it was working...so you work in tandem" *[Health visitor 1]*.

Health visitors talked about the dossier of information about non-medical sources of support they kept, which came from their knowledge of the local area and had been accumulated over time.

The primary focus of district nurses was the clinical nursing care needs arising from an individual's medical condition:

"our priority is their nursing and clinical needs...if you recognised that, you know, that there's something not right here, this person can't afford basic, you know, soap and water and food and heating...it does raise questions, but I think we're limited *[in what we can do]*" *[District nurse 2]*.

Overall, there was a feeling that identifying needs beyond those affecting a clinical condition was not part of a district nurse's role. Referring or signposting to non-medical sources of support was not considered as part of their routine work. Hence, they talked

about a more limited collection of information. The following district nurse believed that helping people to access alternative sources of support provided in the community was unnecessary:

“everything that they’re needing is within that [*National Health Service*] framework” [*District nurse 7*].

The general practitioners, in this study, described their role in terms of treating individual’s medical condition:

“I deal with everything from acute illness to chronic disease management...investigating their various problems” [*General practitioner 2*].

Even though an awareness of wider social problems was expressed, there was a feeling that by the time people presented to doctors, it was too late to deal with any underlying problems:

“we have a problem with underage drinking...as doctors I’m not sure that there’s hellish much that I can do, by the time people walk in through my door it’s probably too late” [*General practitioner 1*].

Addressing social issues was not felt to be a legitimate part of a general practitioner’s job:

“is it really my job to refer people to the Citizen’s Advice Bureau?, is it really my job to tell them about their weight?, they’re social things...we don’t really have the expertise” [*General practitioner 2*].

General practitioners seemed to expect that information about non-medical sources of support would come into them in the form of leaflets or representatives from organisations coming into the practice to discuss their services. They did not strive to find out about sources of support:

“I never go very far to look for the information...I guess if you went through there [*the waiting room*], I haven’t chosen to do so...you’d probably pick up leaflets about a dozen societies or support groups and there are probably notices up” [*General practitioner 1*].

This theme has described a difference in outlook between the different disciplinary groups of prescribers. Health visitors depicted how they looked at the individual's social circumstances as well as their presenting problem. District nurses talked about their focus on the individual's presenting clinical condition and social issues were considered only when they impacted on that problem. General practitioners discussed their responsibility for the treatment of an individual's medical condition rather than underlying social issues. This led to variations in the needs that could be potentially identified and the range of support services suggested.

### ***We're responsible***

Simply knowing about a non-medical source of support was not necessarily sufficient for a health professional to 'prescribe' the service. Prescribers expressed concerns about the quality of non-medical sources of support.

On the whole, community nurses expressed a sense of responsibility for any decisions they made in relation to social prescribing. Decisions involved judging whether an identified need might be better addressed by an alternative service rather than those available through mainstream services:

*"we've got to be careful with that [suggesting non-medical sources of support], I think it's just professionally because we work for [the] health board that [if] we're referring them [patients] to an outside agency, if they was any come [back], you know, I think we've got to be careful" [District nurse 5].*

In general, prescribers expressed a higher degree of trust in organisations that were either provided or endorsed by the statutory sector:

*"you know if it's something that's run by education or the health board...that it will be a certain level, but voluntary agencies I don't know, I cannae tell that" [Health visitor 5].*

This perception seems to be based on an underlying assumption that services provided by the statutory sector are delivered with a certain level of competence, whereas questions

were raised about the advice being given by third sector organisations. Linked to these concerns were doubts about their training and monitoring. However, there seemed to be a degree of confusion about third sector organisations. No differentiation was made between groups run by unpaid volunteers and those that employed and trained their workers.

### **Connected?**

The links between the primary healthcare professionals and the providers in the case study sites were limited. Even though the prescribers were working in the geographical area of the projects, there was, with the exception of the carers' centre, a lack of awareness of their activities:

“I'm not fully aware of the services it [*the lifestyle project*] provides...em, it's not something you hear much about locally” [*District nurse 2*].

Being able to meet providers of non-medical sources of support was, however, valued. On the whole, for the general practitioners and district nurses, opportunities to network with providers were restricted to those who came into their practices. In contrast, health visitors were more likely to make personal contact with non-medical sources of support. Having personal contact enabled prescribers to be aware of a person to contact rather than just a service:

“we have a very nice welfare lady...I would ask [*name*] to visit them [*service users*]” [*District nurse 4*].

These connections seemed to enhance knowledge and confidence in the services being provided.

### **Providers' perspectives**

We identified two main themes. In the first providers express their belief that they were providing a service that was different from mainstream health services. The second theme

explores the providers' perception that they have had to work hard to build relationships as a basis for prescribers to have confidence to refer patients to them.

### ***We can offer more***

Providers described their role by contrasting it with their perceived role of health professionals in primary healthcare. Overall, they believed that they were able to help service users in ways that health professionals, in particular doctors, were unable to:

"I think we can...help people more than they could [*get*] from just going to the doctor" [*Lifestyle project provider 4*].

Even though, providers were asked, specifically about community nurses, there was a focus on general practitioners, which seems to echo a prevailing tendency to equate primary healthcare with primary medical care (Silk 2008).

Predominantly, the providers felt that they were able to spend more time with service users than prescribers could:

"they [*the doctors*] don't give them [*service users*] a lot of time...whereas we...give them as much time as they want, they come and chat and blether where like the doctor's just in and out, you know, 7 minutes or whatever it is" [*Lifestyle project provider 3*].

The extra time was thought to be important to enable providers to see people as individuals by listening carefully to them:

"it's picking up on the little clues in a long conversation...just to get the gist of the person" [*Community health project provider 4*].

The 'little clues' helped the providers understand an individual's personal resources such as confidence which was believed to be key:

"it's about that individual...for instance we deliver literacy here, now there are...other literacy providers but they provide on a group setting...[*but*] everybody's at a different learning level, and a different confidence level...the people that I worked with on a one-to-one basis, if they'd gone to the group...it would've scared them off...I think, that's about knowledge about...the person you're working with" [*Community health project provider 3*].



The phrase, 'the person you're working **with**', was one way that these providers expressed the participatory mode of relating to service users which they endorsed. This implies that that service users were not considered passive recipients of help; rather they were felt to have an active role in addressing their issues.

Doctors were criticised for not treating people as individuals, unique in their social circumstances; instead seeing them as 'patients' or a 'number':

*"[in our service] it's not a case of, 'right...here's a prescription, bye', next person in, that it's not a conveyor belt" [Lifestyle project provider 1].*

By likening an appointment with a general practitioner to a 'conveyor belt', this provider implies that a consultation can seem an unfriendly, mechanised, event. Providers described their services with words such as 'informal' and 'relaxed', whereas words such as 'clinical' and 'judgmental' were linked with doctors:

*"I think they relax more if it's, if they feel it's a non-clinical stance you're taking, and you're inclined to be less judgemental" [Community health project provider 4].*

### ***We've built the connections***

In general, providers felt that their relationships with primary healthcare professionals had been the consequence of their own efforts. They reported that they had taken the initiative and responsibility for building connections with potential prescribers, and that this effort had taken time:

*"we've built up a relationship...that's taken quite a long time...we've managed to...gain that trust and let them see that, yes we do, em, deliver quality services" [Community health project provider 3].*

The providers' perception that building the relationship was their responsibility may reflect the differing value placed on the relationship by the two stakeholder groups. Prescribers, apart from health visitors, did not consider that helping people to access non-medical sources of support was a key aspect of their role. Thus, they may not have been motivated

to make the connections, whereas providers may depend on their relationship with prescribers for the continued existence of their organisation or service.

At a local level, providers talked about making links with general practices through practice managers rather than the health professionals who were delivering care. These connections had led to the development of a reciprocal relationship between the carers' centre and a few of the general practices:

"I've got a good relationship with nine different [GP] surgeries out there...they'll refer onto me, I'll let them know if somebody comes into the carers' [centre] and we sort of built up that relationship" [Carer provider 1].

However, the community health project's attempts to develop links with local primary healthcare professionals had had limited success:

"we've given out information to practice managers, yet none of the actual people that deliver the services have heard of any of the stuff you've given to practice managers" [Community health project provider 3].

This observation may be, in part, a reflection of the complexities of the organisation of primary healthcare services. Practice managers and community nurses, for instance, have different employers and may be based in different buildings, even though they have a responsibility for the same practice population.

Providers voiced a feeling that the third sector was not respected by statutory agencies and health professionals:

"I think statutory agencies have, perhaps, viewed the community and voluntary sector as maybe a bit less professional" [Community health project provider 3].

However, they felt that gaining recognition for their services at a strategic level helped to build confidence in their services amongst individual practitioners. This strategy seems to mirror perceptions expressed by health professionals when they suggested that they had more confidence in making a referral to a non-medical source of support that had been endorsed by a statutory service.

## **DISCUSSION**

Interventions, such as social prescribing, are passed down from a policy level to frontline practitioners. This paper has examined social prescribing as a case study of collaborative working between primary healthcare professionals and providers of services in the third sector, and has identified significant barriers to collaborative working. In what follows, we discuss the findings in relation to the three dimensions of social capital, before coming to a general conclusion.

### **Cognitive social capital: Shared understandings between prescribers and providers**

According to social capital theory, positive relationships between people depend on a certain degree of shared understandings between them (Wakefield et al. 2005). In this study, different belief systems were evident. Health visitors seemed to subscribe to a social model of health which considered an individual's surrounding circumstances, as well as their presenting issue. As a consequence, they looked for and retained information about a wide range of non-medical sources of support. Similarly, the providers appeared to be aligned to a social model of health, emphasising the importance of building an individual's resources such as confidence. In contrast, district nurses and general practitioners were less likely to consider non-medical sources of support as useful or relevant to their role, had less knowledge of local non-medical sources of support, and were disinclined to actively engage in social prescribing.

In this study, the prescribers tended to position themselves as the 'experts'. Within the 'expert' model, practitioners are trained to solve people's problems and tell them how to live happier and healthier lives (Bidmead et al. 2002). By identifying needs and suggesting solutions, prescribers remained in control of the agenda. In contrast, providers appeared to position service users as being in control and activities were understood as taking place

'with' rather than 'for' people. Overall, the 'culture of care' of the two sectors was distinguished by differing values regarding the beliefs and empowerment of the individual service user.

Primary healthcare professionals have a key role in social prescribing, serving as 'gatekeepers', and referring patients on to non-medical sources of support in the community (Mossabir et al. 2015). If health professionals do not perceive such sources of support as valuable or relevant, they are unlikely to make use of them.

### **Relational social capital: Prescribers' and providers' perceptions of their relationship**

We found a lack of trust between prescribers and providers. Trust is a key factor in the creation of co-operative relationships between representatives of organisations (Stern et al. 2005, Rugkasa et al. 2007). Trust is built through a history of interaction that, in turn, enables effective communication between stakeholder groups (Casey 2008). In this study, prescribers were mistrustful of unknown third sector organisations, and fearful about their own liability and accountability for referrals made to external organisations. They expressed higher trust in initiatives that were either provided or endorsed by the statutory sector. Perceptions of professional status and power arose repeatedly. Overcoming the perceived power imbalance between the prescribers and providers presents a further challenge to potential collaboration (Irvine et al. 2002, Stern et al. 2005, Rugkasa et al. 2007).

### **Structural social capital: Connections between prescribers and providers**

The networks of the prescribers and providers in this study did not appear to overlap. Network ties enable the development of the processes of trust and communication (Silk 2008, Carr et al. 2006). Trust relations are built through inter-personal interaction. With the exception of the carers' centre, there was limited knowledge of or communication with the case study sites among the prescribers. Without lines of effective communication, it is

unlikely that the shared understandings necessary for the formation of a co-operative relationship will develop (Casey 2008, Carr et al. 2006).

### **Study Limitations**

The findings of this study should be considered in the light of the following limitations. This study was limited to participants working and living in one Health Board area in Scotland. It is possible that the working practices and organisational structures may have differed from other potential settings. The visibility and strength of organisations in the third sector may differ in other settings. Although this may affect the transferability of the findings, the tensions of collaborative working between statutory sectors and the third sector are well documented (Carr et al. 2006).

This study relied on self-report. Participants may have given answers to the questions in ways that were perceived to be socially desirable to the researcher (Robson 2002), who came from a community nursing background. Shared understandings may have limited the ability to effectively interrogate taken-for-assumptions. However, the process of analysis and resultant interpretation were discussed at length by the co-authors to help challenge any assumptions made.

The small number of general practitioners that took part in this study limits the transferability of any findings from this particular disciplinary group. The participants may not be typical of the broader workforce; all were male and had been qualified as doctors for more than 15 years. A younger and/or female group of doctors may have had a different outlook from those interviewed.

### **CONCLUSION**

In this study, social prescribing was hindered at grass-root level by the absence of meaningful social capital linking the primary healthcare professionals with the third sector

providers. Professionals are socialised, through their education, to adopt a discipline-based framework that determines particular definitions of their role, status and field of practice (D'Amour et al. 2005), as well as that of other professions. These set ways of thinking are not habitually addressed as a part of strategic level collaborative working arrangements. Yet if they deter professions from working together, they may fundamentally undermine any agreements.

Social prescribing is one instance of a range of efforts, across welfare states, to promote joint working between statutory and community or voluntary sector groups (e.g. Kilpatrick et al. 2009). In each context, partnership policies and promises are put into practice through the effort, communication and interaction among frontline staff. Our findings, while based in the West of Scotland, are likely to have relevance to other settings in which partnership working is advocated. The main transferable lesson from this study is that efforts at strategic levels to strengthen links between third sector and statutory services need to be complemented by efforts to build shared understandings, trust and connections between the diverse frontline workers whose co-operation is necessary to make collaborative working more effective.

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**Table 1: Participants**

Stakeholder group		Gender		Setting		Length of time with project/in practice area	Interview duration
		Male	Female	Urban	Rural		
<b>Providers:</b>	Lifestyle project	2	4	Mixed		3-7 years	26-46 minutes (av. 38 min.)
	Carers' centre	0	4	Mixed		1-9 years	41-101 minutes (av. 69 min.)
	Community health project	2	3	Urban		3-14 years	41-80 minutes (av. 60 min.)
<b>Prescribers:</b>	Health visitors	0	7	6	1	2-15 years	38-72 minutes (av. 53 min.)
	District nurses	0	8	7	1	2-20 years	34-66 minutes (av. 51 min.)
	General practitioners	3	0	2	1	5-28 years	42-47 minutes (av. 44 min.)
	<b>TOTAL (n=33)</b>	<b>7</b>	<b>26</b>				<b>27-101 minutes (av. 54 min.)</b>

**Figure 1:** Social capital: a theoretical framework (adapted from (DiCicco-Bloom et al. 2007), pE16).

