An Evaluation of Maryhill and Woodside Child Health Initiative

FINAL REPORT

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December 2005

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Acknowledgements

We would like to thank the Child Health Initiative's Partnership Steering Group for commissioning us to carry out this work and for their input into the evaluation. We are particularly grateful to Susan Dawson, Child Health Coordinator for her practical support with the evaluation.

This report refers to the views of a wide range of participants from different organisations including health, social work, education, other local authority departments and the voluntary sector. We hope that the report does justice to their viewpoints and will provide a reasonable basis for moving forward within new primary healthcare structures.

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EXECUTIVE SUMMARY

This evaluation was commissioned by the Partnership Steering Group of the Maryhill and Woodside Child Health Initiative (CHI) to assess the impact and development of the CHI, and to consider the implications of the changing structure within primary healthcare. A combination of documentary analysis, survey, focus group and individual interviews collected data from those involved with the initiative. The majority of evaluation participants were from the health service. The evaluation took place over three months between September and November 2005.

The CHI began in 2003 and has two paid staff, a Child Health Coordinator and Family Support Worker. The work of the CHI is directed by a Partnership Steering Group comprising 10 members across the statutory and voluntary sectors. It is an initiative to support professional networking and provide family support services across Maryhill and Woodside. It is a health focused preventive initiative. It has four main aims, which are to:

1. Promote healthy families and healthy communities
2. Improve the local structure for delivery of services
3. Improve joint working arrangements
4. Enhance community based services

A strategic approach based on four main themes has been implemented. These themes are family support; positive parenting; information for parents, and joint training.

Key Findings

* Experienced professionals, who were part of wider partnership networks, and who shared values about inequality and the agenda for action, provided the impetus to set up the CHI.
* The CHI displayed many of the key features of successful partnerships as identified by the literature such as having common aims, acknowledging the existence of a common problem and having a shared vision of outcomes.
* The survey respondents most frequently reported that they shared the CHI aim of 'promoting healthy families and communities'.
* The theme of 'positive parenting' was viewed by respondents as of most relevance to their own work.
* Respondents identified priority areas of CHI work as 'coordination' and 'family support'.
* 'Promotion of wide community participation in planning and developing policies and practices' was viewed by respondents as of least priority.
* The four main strengths of the CHI were identified as the quality of the relationships among partners; the focused task-centred approach; the wider

context of collaborative working and its health focus; and skilled and experienced staff.

* According to survey respondents, the CHI has been successful in achieving its general aims and objectives.
* The greatest positive impact resulting from the CHI was in the growth of knowledge and increased coordination of quality family support, and in the increased coordination and accessibility of information for parents.
* They identified gaps in the level of participation from a number of agencies.
* The extent of participation by parents and the community was identified as an issue to be addressed but there was ambivalence about the appropriate way to do this and its' timing.
* The private sector was not identified as a partner.
* As it was believed by participants that the initiative was already having a significant impact, many suggestions for future development were concerned with consolidating and building upon existing arrangements.
* Although it was not possible to identify the specific cost of the initiative for this evaluation, a number of participants identified developments requiring additional funding, a more secure funding base and more time.
* A number of new developments were identified by evaluation participants should sufficient resources be available such as work with fathers, community engagement, research and evaluation.
* It was unclear to evaluation participants how imminent changes in management and service structures resulting from the CHSCP will affect the CHI.
* The CHSCP was seen by some as a potential opportunity for development and enhancement of the CHI and for rooting it more firmly within strategic developments.
* However, there was still caution about how change will affect individual practitioners and services in practice.
* The strong foundation of professional partnership and service coordination should ensure the CHI is flexible and adapts to change in the context of new management and service structures.
* The existing commitment and drive of those involved and what has been learned from professional partnership working should enable the initiative to evolve and embrace wider participation of local parents and other sectors.

RECOMMENDATIONS

Membership & participation

1. The members of the PSG and other participants in the CHI are predominantly from health services and the statutory sector yet aims are broad and could potentially involve a wider range of disciplines, all sectors, and participants. Now that solid foundations have been laid by existing members, it may be time to review membership to ensure that it is representative of all members who can contribute to the project aims and are compatible with the purpose of new structures as they evolve.
2. Members of the CHI team were not included as members of the PSG in terms of this evaluation to avoid role confusion. However, it appears the Child Health Coordinator is classed as a member of this group. This may be an operational issue for the CHI that requires discussion and clarification by the PSG.
3. Participation of other potential key stakeholders (e.g. local parents or the private sector) needs to be addressed particularly in view of the remit of the CHSCP. Now that professional partnership is working well, this may be the time to consider ways of including these other key stakeholders in a meaningful way. For example, the promotion of regulated (private sector) childcare such as childminding could be considered.
4. A joint protocol for FSW referral is in place. Protocol for joint training is being developed although there may be others that would make the CHI more widely accessible and open up the agenda e.g. role and responsibilities of the PSG and membership, participation, making a contribution to partnership planning.

Partnership development

5. A primary task for the PSG has been to decide on the roles and responsibilities of the Health Coordinator and FSW and therefore the group has tackled this. However, the roles and responsibilities of individual members of the PSG were not clear to an outsider. There did appear to be, for example, an expectation that communication from individuals to their respective agency about the work of the PSG and vice versa was a two way process. Clarification of this role and others (in writing) could be helpful and then open for discussion and review.
6. The message from the Audit in 2004 was clear that expertise in professional partnership working had been developed in the CHI and in other parts of the area and this should be shared and extended. It is recommended that the CHI develop opportunities to share their expertise in partnership working, through presentations, for example, highlighting the essential ingredients.
7. The establishment of the CHSCP should be viewed as an opportunity to proactively present the PSG and CHI expertise on professional partnership working to this group as a means of supporting and shaping its' development.

8. It was not clear exactly how this project inter-faced with other initiatives and as a group exercise this would be useful to review and develop. This is necessary if a goal of increased participation is pursued. Similarly it may be that the CHI team members may be more effectively linked to other structures.
9. Perceptions of partnership in the professional local community were explored in respect to the CHI and correspond with key characteristics identified by Harrison et al (2003). These characteristics may be useful to the PSG for discussion, the development of presentations and as a guide for future development.
10. Similarly, the Partnership questionnaire could be used to further explore this concept and review changes. The survey questionnaire could be adapted and changed for future use.
11. Making explicit shared meaning and of terms would be an exercise that could assist the PSG towards further development. Differences of opinion may emerge during the process of clarification but this would be helpful to the process and adaptation to change.

Monitoring and Evaluation

12. Since the CHI aim of *promoting healthy families and healthy communities* was the single aim that everyone considered to be either 'important' or 'very important', there should be some clarity about measurement. All other aims were given a wider range of responses. A 'logic model' of evaluation could provide a useful framework as a means of systematically clarifying links between aims and outcomes and for use in ongoing, internal evaluation.
13. The tasks of coordination are difficult to articulate in concrete terms, it is recommended that the Health Coordinator keep a contact diary for a fixed period (e.g. a month) in which she records the type of contacts (phone, meeting, individual), time, and with whom she is in contact. This should be analyzed at the end of the month to show what percentage of time is spent on each of the various activities or types of contacts towards specific outcomes.
14. A retrospective pre-test was used as part of the survey questionnaire and is recommended as a useful evaluation tool for gauging change (outcomes) – especially useful when linked with other demographic characteristics. It is quick, only needs to be completed once, and can be used to pinpoint and compare perceived change in particular areas. It is a method, however, which is susceptible to overly positive responses.
15. The development of an evaluation strategy based on a logic model framework would be a useful group exercise for clarifying the purpose and outcomes of particular activities and the underlying assumptions. A description of this model and tools to support it are appended. This will require separation of outcomes in terms of short, medium and long-term. These could be further sub-divided into outcomes that are at a community, family or individual levels. Given the importance of the development of participation, this should be addressed alongside each outcome.

1. BACKGROUND

1.1. Introduction

Two years into the implementation of the Maryhill and Woodside Child Health Initiative (CHI), its Partnership Steering Group (PSG) decided to commission an independent evaluation to assess:

- How the Child Health Initiative is being implemented, and what progress has been made
- The strengths and challenges of the partnership process
- The perceived effectiveness and impact of the CHI
- The potential impact on the CHI of the changing structure of primary healthcare in Scotland

This report presents findings from an independent evaluation carried out over a three-month period during 2005 for the PSG and NHS Greater Glasgow Primary Care Division, which set out to explore these questions.

1.2. Context

The CHI was developed within the context of a history of promoting partnership working in the field of child welfare; an increasing policy emphasis on the importance of partnership working in public services; growing recognition of the importance of developing and delivering health and other public services in partnership with service users/patients and the public; and in response to identified local needs and priorities.

1.2.1. Partnership Working in Child Welfare

A recent review of front-line working with children and families (Frost, 2005) asserts a growing emphasis in child welfare on working together in partnerships across professional and organisational boundaries, and partnership as a key theme of child welfare in recent decades. Concerns regarding coordination and cooperation link back to the origins of British child welfare. However, Frost traces the modern emphasis of working together to the high profile of child protection cases, in particular the death of Maria Colwell in 1973.

The need for services to be coordinated, for joint working and to be working in partnership are, however, just as important for effective family support as for child protection. Similarly, being effective at meeting the needs of children with disabilities, which cross several organisational boundaries, clearly demands a more joined up partnership approach. It is not surprising therefore that inter-agency partnership work is at the centre of legislation such as the Children (Scotland) Act 1995 and related guidance. This stems from a concern that fragmentation of services can have

a negative impact on the outcomes for children and families. Recent guidance on protecting children and young people (Scottish Executive, 2004) further emphasised the necessity for professionals to work together to assess needs and risks, to share information, to jointly plan and to demonstrate that services are provided in a coordinated way.

1.2.2. Policy Emphasis on Partnership Work

The Maryhill and Woodside CHI was created at a time of increasing policy emphasis on partnership working within the NHS and other public bodies. The concept of partnership work is fundamental to central government's vision as set out in the White Paper *Designed to Care* (SEHD, 1997). Although the idea of different agencies working together is not new, recent governments have emphasised joint working to a greater extent than in the past. More recently, the growth of the term 'partnership' to describe a range of programmes, arrangements or initiatives involving more than one agency or organisation is a documented feature of welfare reform and development under New Labour (Stanley, 2005; Harrison et al, 2003).

According to some contemporary writers, the promotion of partnerships emerges out of a recognition that traditional systems of political control are unable to deliver (Rhodes cited in Stanley, 2005). Neither are they able to manage the necessary reform of public services. According to such commentators, partnership is a form of co-ordination and co-operation arising out of shared goals and mutual advantage, a necessity arising out of the failure of traditional systems. It is now accepted that no single professional group can achieve improvements in the health of the public and that a broader multi-agency and multi-disciplinary approach is needed.

The growing amount of literature on the subject of partnership shows that the term is applied to any kind of relationship between different agencies, that there is no single, agreed definition and that the term is often used interchangeably with collaboration (Harrison et al, 2003). Even the following clear definition offered by Tennyson (1998) falls short of encompassing everything about partnership:

> *"A cross sector alliance in which individuals, groups or organisations agree to: work together to fulfil an obligation or undertake a specific task; share the risks as well as the benefits; and review the relationship regularly, revising their agreement as necessary."*

Although an ideal to aim for rather than a norm to expect, Harrison et al (2003) identify certain key characteristics of successful partnerships as:

* Involving more than two agencies or groups and including the key stakeholders
* Having common aims, acknowledging the existence of a common problem and having a shared vision of what the outcome should be
* Having an agreed plan of action or strategy to address the problem

* Acknowledging and respecting the contribution that each partner can bring
* Being flexible and seeking to accommodate the different values and cultures of participating organisations
* Consulting with other relevant parties that are not part of the partnership
* Exchanging information and having agreed communication systems
* Sharing resources and skills
* Involving the taking of risks
* Establishing agreed roles and responsibilities
* Establishing systems of communication between partners and relevant agencies.

Frost (2005) offers one conceptualisation of partnership in his review of joined up work in practice for front line professionals working with children and families. A continuum from 'no partnership' and 'co-operation' through to 'merger and integration' is conceptualised and is illustrated in the following diagram:

Frost's ladder of partnership and joined up work

Level 4	**Merger/integration** – different services become one organisation in order to enhance service delivery	
Level 3	**Co-ordination** – services work together in a planned and systematic way towards shared and agreed goals	
Level 2	**Collaboration** – services plan together to address issues of overlap, duplication and gaps in services provision towards common outcomes	
Level 1	**Cooperation** – services work together towards consistent goals and complementary services, while maintaining their independence	
	No partnership	

Current knowledge suggests that for partnerships to be effective there needs to be ownership as well as appropriate sharing of responsibilities across all agencies involved. Success is dependent upon organisations being flexible and defining clear links between the partnership groups and the strategies of organisations. Different rules, constraints and priorities can easily inhibit effective partnerships. Therefore, how 'partnership' is defined and understood by the different partners involved can

have a significant impact on its effectiveness.

1.2.3. Partnership with Service Users and the Public

User and public involvement has been a growing priority area for policy within the NHS in Scotland as set out in *Our National Health* in 2000. The subsequent document, *Patient Focus and Public Involvement* (2001), and the development of standards in respect of 'patient focus' set out how the required change in culture could be made a reality. This emphasised that NHSScotland should be responsive to patients' needs and focused on action to meet those needs. The Executive's vision is of a health service:

* Where people are respected, treated as individuals and involved in their own care;
* Where individuals, groups and communities are involved in improving the quality of care, in influencing priorities and in planning services; and
* Designed for and involving users.

(Scottish Executive Health Department, 2005)

Creating a *"patient focused NHS"* is perceived as an important part of the *"quality improvement agenda".* Collaboration through partnerships between government and local communities has been emphasised as a new approach to government:

> *"The involvement of communities…through consultation and through local representation in partnerships structures, gave solutions a new legitimacy. At the local level new partnership structures were developed to deal with problems concerning youth crime, drugs, unemployment and health." (Harrison et al, 2003, p9).*

Significantly, the evaluation was commissioned at a time when management structures were evolving to reflect a new and enhanced role for primary healthcare in service planning and delivery, underlining the importance of partnership with service users and the public. Local Health Care Cooperatives (LHCCs) were evolving into Community Health Partnerships (CHPs), or as in the case of Glasgow, into Community Health and Social Care Partnerships (CHSCPs). The new partnerships have a responsibility to effectively involve and engage local people and groups and to develop a local public partnership forum (PPF) to maintain an effective and formal dialogue with local communities as well as with other partners (Scottish Executive, 2005). Successful development of CHPs and PPFs are considered as central to the delivery of the Government White Paper *Partnership for Care (*2003) and the NHS Reform (Scotland) Act 2004.

The development of a PPF in each local area and its links with the CHP is about strengthening relationships between health services, community groups and individuals as well as with other partners. PPF will have three main roles: first, to inform local people about services the CHP is responsible for; second is to engage local service users, carers and the public in discussion about how to improve health

services; and third, its role will be to support wider public involvement in planning and decision making (Scottish Executive, 2005).

1.2.4. Identification of Local Needs

As part of the implementation of the national Primary Care Strategy, funding for short-term initiatives or ongoing services was received by each LHCC under the Local Initiative Funding (LIF). The main emphasis of LIF initiatives was to be on health improvement, partnership working and the development of local services in response to locally identified need. Maryhill and Woodside LHCC identified their priority as promoting the health of children and families. This was arrived at on the basis of an audit of local needs involving parents as well as professionals, and at a consultation seminar involving a range of key stakeholders from the statutory and voluntary sectors (Consultation Seminar, 2002; Fairley, 2001).

Specific gaps in service and unmet demand were identified by an audit of childcare services (Fairley, 2001). As there were no specific LHCC developments for children and families, this was considered within the LIF framework (Seminar report, 2002). A clear link between poverty and poor health in Maryhill was highlighted and it was argued that existing knowledge showed that good health in the early years of life has a positive influence on health throughout the life course. The need for better joint agency structures to facilitate, coordinate and support early intervention/prevention was highlighted. In addition to developing new services, it was argued that better joint working would improve the effectiveness of existing services provided by a range of agencies. To achieve the broad service objectives identified, it was proposed to create a Child Health Initiative by establishing two child health development posts, to be directed by a local partnership steering group and line managed by the LHCC General Manager.

2. PURPOSE AND METHODS

2.1. Purpose of the Evaluation

The Evaluation Brief stated the purpose of the evaluation as to:

* Assess progress of the initiative in relation to objectives agreed in the service proposal report
* Inform future planning and development of services for children and families within the new Community Health Partnership arrangements

The overall purpose of the research was to evaluate the process and perceived impact of the Child Health Initiative. It had three main objectives, which were to:

1. Assess progress of the posts of Child Health Coordinator and Family Support Worker
2. Assess the strengths and challenges of the partnership process
3. Evaluate the action plan of the Partnership Steering Group

It was also stipulated that the evaluation should consider the future implications for the CHI of structural changes in primary care, that is the change to CHPs and the impact on local infrastructure. Given that the North West Community Health and Social Care Partnership was being developed during the time of the evaluation, the research focus was on perceptions of relevant stakeholders of its potential rather than actual impact.

2.2. Evaluation Methods

To collect the range of information implied by the Evaluation Brief, it was necessary to consult with a wide range of key stakeholders in the area, and to use a variety of methods. In summary, the main methods used in the evaluation were:

1. Review of relevant documents and literature
2. Interviews with key post holders – Child Health Coordinator and Family Support Worker and the CHI line manager
3. A questionnaire survey of relevant agencies and staff involved in some way with the partnership process or with implementing the action plan
4. A group interview with all members of the Partnership Steering Group

The main methods are now explained in more detail below.

2.2.1. Brief review of documents

The Initiative's progress reports, minutes, the service proposal report and written action plan of the Partnership Steering Group were obtained as were copies of the

two audits of childcare services and the seminar report from 2002. A limited amount of relevant literature on partnership work as well as the changing structure of health services was also reviewed to set the study within the wider context.

2.2.2. *Interviews with key informants*

Face to face interviews with the two relevant post holders and the line manager were carried out at the start of the evaluation. The interviews covered six main topics including:

* The history and background of the CHI
* Meaning and understanding of 'partnership'
* The aims and objectives of the CHI
* Perceived outcomes and achievements
* Strengths and challenges of the partnership process
* Ideas about future developments

As requested in the Brief, consent was sought from staff to participate in the research. The purpose and methods of the research were explained in advance either by one of the researchers or Child Health Coordinator, and the two post holders signed a written consent form prior to the interview. Due to local circumstances, the interview with the line manager was conducted by telephone.

2.2.3. *Questionnaire survey*

A questionnaire survey (See Appendix) was sent during October to approximately 60 individuals in a range of agencies, including all those who were or had been involved with the CHI in some capacity. This included members of the PSG, staff in the public health team, those who had attended the original seminar in 2002, those who had been involved in training and/or other joint events, and those who had referred to the Family Support Worker. The Child Health Coordinator identified the list of potential questionnaire respondents, and consulted everyone on the list prior to the questionnaire being sent. In response, 21 consents were received, which meant some of the questionnaires had to be distributed from Maryhill and Woodside LHCC to preserve anonymity.

The questionnaire sought to examine respondents' involvement with the CHI, their perceptions of the aims and themes, its strengths and benefits, perceived outcomes and suggestions for improvement. A reminder was sent by the Child Health Coordinator, which increased the response rate slightly.

2.2.4. *Group interview*

A group interview was carried out with all members of the PSG. At the start, members were asked individually to complete a brief questionnaire (See Appendix) to assess their level of agreement with different domains of partnership and these

were analysed later. In the USA, a range of measures have been developed to assess effectiveness in the development of collaborative relationships (See Taylor-Powell et al., 1998). Such tools were referred to in developing the Maryhill partnership questionnaires.

The group interview covered three main areas: members' understanding of partnership and the role of the CHI; identifying what members considered to be its main achievements and successes with reference to the four key themes; and exploring what they perceived as positive and negative aspects of the CHI and ideas for improvement. The two-hour discussion was tape recorded and transcribed in full alongside summaries recorded on a flipchart.

2.3. Data Analysis

Qualitative analysis included initial review of written documentation to identify relevant information for the evaluation. Interviews were recorded by hand at the time of interview, and the group discussion was tape recorded and written up on flipcharts and notes. Key themes were drawn from the data and the literature and this provided the basis for making recommendations. Quantitative analysis was based on descriptive statistics and analysed using SPSS to examine patterns and identify potential barriers to partnership development. Basic statistical analysis was undertaken.

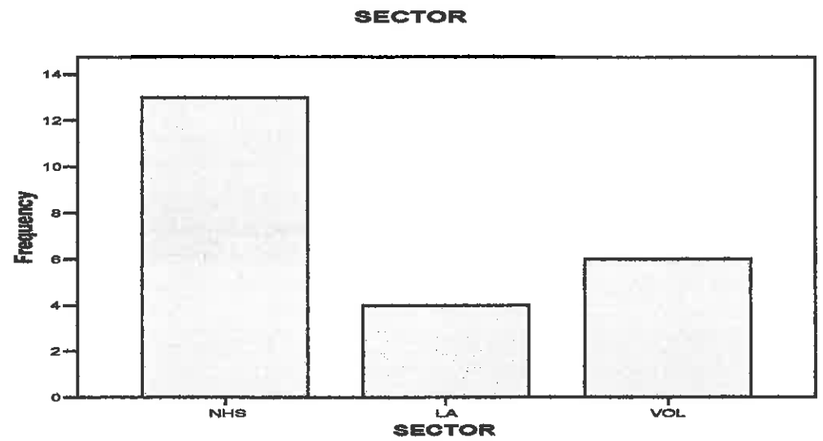
3. PROFILE OF SURVEY RESPONDENTS

There were 23 respondents to the survey, representing a response rate of 38%. All were professionals working in the Maryhill and Woodside areas. In summary:

* More than half of respondents (56.5%) were employed by the National Health Service, such as Greater Glasgow NHS Board, Glasgow Primary Care NHS Trust, Community Health Centre, Maternity Services etc.

* Over a fifth of respondents (26%) were employed in the voluntary sector, including Happy Days Community Nursery, NCH San Jai Chinese Project, Maryhill Mobile Creche, Maryhill Community Health Project etc.

* Only four respondents (or 17%) were employed by the local authority, including Social Services, Glasgow City Council – Education Services and Glasgow City Council Cultural & Leisure Services.



The majority (86%) of respondents were female. Similarly, most (83%) were white and there were 17% (4 respondents) from various ethnic minority groups, including Black/African, Pakistani, Chinese and "European". Only one respondent was resident in the Maryhill and Woodside area and one had a chronic health problem or disability.

Assuming that respondents were broadly representative of local workers, it appears that women who are not resident in the locality are predominantly taking responsibility for professional networking, the promotion of health and family support and other tasks associated with the CHI in the area. The representation from ethnic minorities indicates that the CHI is engaging with members of diverse ethnic groups.

The job titles of respondents covered four main categories:

* Health visitors – 7
* Public health practitioners & health promoter – 3
* Managers/ Coordinators – 8
* Community /project development - 5

There was a considerable amount of knowledge of the area and local work experience amongst those who responded with a majority (78% or 18 respondents) who had worked in the Maryhill and Woodside area for 3 years or more. Over a fifth (6) had worked locally for six years or more. Similarly, a majority (72%) of respondents had previous experience of collaborative work in this community.

4. THE MARYHILL AND WOODSIDE CHILD HEALTH INITIATIVE

4.1. Overview

The Child Health Initiative (CHI) was created by the Maryhill and Woodside LHCC following on from an audit of childcare services and a consultation seminar with local stakeholders. It is described by one of the two post holders within the CHI as meeting *"a gap in the coordination of services"*, rather than as a specific project or service, except that it does involve the employment of a Family Support Worker to provide a family support service. The line manager emphasised that this partnership initiative is a *"shared resource even though it is paid for by the Health Service"*. It is an integral component of the network of professionals who are working in services for children and families in the local area.

The CHI began its life in 2003 with the appointment of the Child Health Coordinator. Its four main aims were defined[1] as to:

* Promote healthy families and healthy communities
* Improve the local structure for delivery of services
* Improve joint working arrangements
* Enhance community based services

Its main purpose was defined as to reduce inequalities in health in respect of vulnerable children and families and to promote their welfare and inclusion. At the first meeting of the Partnership Steering Group it was agreed that the CHI would develop a strategic approach based on four related themes, which were:

1. Family support
2. Positive parenting
3. Information for parents, and
4. Joint training.

4.2. The CHI Team

There are two paid staff in the CHI team: the Child Health Coordinator and the Family Support Worker. Both were located within the LHCC at the time of the research and shared offices with members of the Public Health Team.

4.2.1. Child Health Coordinator

The Child Health Coordinator identified her main role as one of coordination:

[1] Maryhill and Woodside LHCC Partnership Steering Group – Early Years Child Health. Action Plan: 2005/2006

"I act as a catalyst to support people in joint working at practitioner level. It's a strategic post but working at a practitioner level…My job is to implement the action plan. I work around the four main themes….My background is originally in nursing and more recently in health promotion and health improvement"

The remit of this post is to promote the health of children and families with a main focus on the early years. The post holder works closely with other local service providers, local planning groups and with nursing staff to implement the main aims and themes of the CHI.

4.2.2. Family Support Worker

The Family Support Worker has a clearly defined service role:

"My post as Family Support Worker came out of the Initiative. There was found to be a need in the community for more intensive family support on a one to one basis and that's how the FSW came to be set up…My background is in Education. I'm nursery nurse trained and before this post I was working for a mental health project."

The Family Support Worker provides practical home based support for vulnerable families, with an emphasis on supporting the parents. This includes homemaking skills, raising awareness of welfare benefits and helping families to access local services and facilities.

4.2.3. Line Management

"In 2003 Susan came to see me to establish a group to carry forward the recommendations coming out of the seminar from 2001. What came out of that was that children and families was a big thing in this area and we needed a proper organisational set up bringing together the different services including local schools…"

The Child Care Coordinator was line managed by the General Manager for the LHCC, although this arrangement had not been operational for some time due to the manager's ill health and would likely change in response to the impending restructure of primary healthcare.

4.2.4. The Partnership Steering Group (PSG)[2]

The Partnership Steering Group (PSG) was set up at the start of the CHI and included many of the people who had attended the seminar in 2002. The role of this group is to:

* Identify priority issues for developing local services for vulnerable children and

[2] Source: CHI - Maryhill and Woodside LHCC Partnership Steering Group – Early Years Child Health, August 2004 & Focus group, October 2005

families

* Plan and coordinate community based programmes
* Provide direction and support for the Child Health Coordinator
* Consider how the PSG relates to other strategic structures for children and families services, particularly locally.[3]

Until recently, the General Manager of Maryhill and Woodside LHCC had assumed the role of chairperson to the PSG. There were nine members of the group according to the list provided by the CHI, dated August 2004 and this included one member of the CHI team (Child Health Coordinator) and her line manager (LHCC General Manager):

Job Title	**Employment sector**	**Discipline**
Chairperson, CYP Forum & community worker & community centre	Voluntary sector	Community work
General Manager, Woodside & Maryhill LHCC	Health Services	Administration
Child Health Coordinator (CHI Team member), Woodside & Maryhill LHCC	Health Services	Nursing
Health Visitor, Woodside & Maryhill LHCC	Health Services	Nursing
Public Health Practitioner, Woodside & Maryhill LHCC	Health Services	Public health
Community Action Officer, Community Action Team	Local Authority	Community work
Childcare Strategy Development Officer	Education Services	Early childhood education and care
Operations Manager, North West Area Children & Family Services	Social Work Services	Social Work
Senior Health Promotion Officer	NHSGG Health Promotion Department	Health Promotion
Unknown	GCC Leisure & Recreation	Community work

[3] Maryhill and Woodside LHCC Partnership Steering Group Early Years Child Health: Action Plan 2005/2006

Members of the PSG are predominantly from health services and the statutory sector, although aims are broad and could potentially involve all sectors, a wider range of disciplines and participants. There was very little membership turnover from 2004-2005. Turnover that did occur was related to new representation by GCC Leisure and Recreation Services and the absence of representation by the Community Action Officer.

PSG members participated in a focus group meeting and completed questionnaires on the meaning of partnership for the evaluation. Some members may also have participated in the survey.

5. AIMS AND THEMES

"What it's trying to do in a broad sense is to improve child health in addressing inequality, so it's really about child health and what everybody is doing about it locally" (PSG member)

"The Initiative isn't a tangible service as such in itself but a way of coordinating and providing opportunities for a range of services to collaborate in filling the gaps…The Initiative takes a planned early intervention stance rather than providing reactive services…the Initiative takes a planned early intervention stance rather than providing reactive services." (CHI team member)

Quotes from the PSG and a team member above illustrate the broad aims of the CHI and its' underlying philosophy. Different views of the aims of the CHI were assessed through interviews with the Child Health Coordinator and Family Support Worker, the group interview with PSG members, and through the survey questionnaire to measure the extent to which the views of those closely connected to the CHI corresponded with the views of local professionals.

5.1. Relevance of Aims & Themes

In the survey, all respondents were of the opinion that the aims of the CHI were very important in relation to their own work. This was indicated in responses that scored the importance of the aim from 0 (not at all important) to 5 (very important). The standard deviation shows the extent of differences between individual scores.

The promotion of healthy families and healthy communities was at the top with little difference between respondents' views on this. All other stated aims were viewed as important but to a slightly lesser extent and with only slight difference between the perceptions of individuals. One survey respondent highlighted how the aims were *"complementary to both national and local policies and strategies for improving child health and addressing inequality".*

Table 1: Relevance of CHI aims to respondent's own work

	1. PROMOTE HEALTHY FAMILIES & COMMUNITIES	2. IMPROVE JOINT WORKING ARRANGEMENTS	2. ENHANCE COMMUNITY –BASED SERVICES	3. IMPROVE LOCAL STRUCTURES FOR SERVICE DELEIVERY
Mean	**4.9**	**4.6**	**4.6**	**4.5**
Std. Deviation	0.3	0..6	0.6	0.7

As a means of operationalising the aims of the initiative, work is focused in the four, interconnected thematic areas. Under each of these themes the PSG monitors the

work of the Child Health Coordinator and Family Support Worker and sets targets, which are reviewed annually. PSG members describe this as a 'project management' or 'project approach' to managing the work of the CHI:

> *"A project approach to developing something that was not about bricks and mortar and that was about developing different ways of working across all the services "*

Respondents were therefore also asked how relevant the themes of the CHI were to their work. There was considerable agreement about the value of the themes with that of positive parenting viewed as the one of most relevance to respondents own work, but as a couple of survey respondents reported *"the themes do not operate in isolation, they are interrelated."*

Table 2: Relevance of CHI themes

	FAMILY SUPPORT	POSITIVE PARENTING	INFORMATION TO PARENTS	JOINT TRAINING
Mean	**4.6**	**4.7**	**4.6**	**4.6**
Std. Deviation	0.6	0.6	0.6	0.6

5.2. Most Important CHI Activities and Benefits

Top priority areas of work tackled by the CHI that were identified as project strengths and benefits by survey respondents are indicated by these quotes:

> ***COORDINATION:***
> *"Helps to tie together the different services and activities in the area - helps us promote what we have to offer and find out what others have too."*
>
> ***FAMILY SUPPORT:***
> *"Early interventions/support to vulnerable families multi agency approach - non stigmatising built into normal arrangements to support parents/approach child health issues."*

The comments supported the priority given to the aim and thematic area of family support implemented by the CHI. Survey respondents identified these as key areas of strength and benefit arising from the CHI.

Respondents were then asked to identify the three areas of work undertaken by the CHI that they considered as most important. It was found that a high percentage, (86%) considered the provision of family support as one of the three areas of most importance. This area was closely followed by that of the coordination and development of local, multi-disciplinary practices and initiatives. This was reported by 77% of respondents as one of the three areas of importance. These correspond with the aims and two of the themes addressed by the CHI – *Family Support* and the Coordination and development of local, multi-disciplinary practices and initiatives as exemplified by *Positive Parenting*.

Other activities were also identified as important but the frequency was lower. For instance, the contribution by CHI to the development of local children and family policy and planning was reported by 41% of respondents.

The development of accessible information for parents was identified as important by 36% and promoting and developing joint training initiatives by 32% of respondents. Promoting wide community participation in planning and developing policies and practices was reported as important by 27% of respondents.

The development of information for parents and joint training initiatives are also CHI themes but were reported by survey respondents to be of less importance.

Table 3: Frequency of work areas reported as of most importance (in rank order)

Area of work	No. of respondents (n=22)	%
1. Provision of family support	19	86
2. Coordination and development of local, multi-disciplinary practices and initiatives	17	77
3. Contribution by CHI to the development of local child & family policy and planning	9	41
4. Development of accessible information for parents	8	36
5. Promoting & developing joint training initiatives	7	32
6. Promoting wide community participation in planning & developing policies and practices	6	27

6. UNDERSTANDINGS OF 'PARTNERSHIP'

The key themes to emerge from exploring the concept of 'partnership' in this evaluation were:

1. The importance of context
2. Shared meaning of partnership.

The context sets the stage for development and for partnership working to progress towards meeting tangible outcomes.

6.1. The importance of context

All the research participants highlighted the importance of ensuring dedicated time for planning and relationship building as main reasons for developing the CHI and the post of Child Health Coordinator. Two PSG members considered that the dedication of a post for coordination and time for planning had been an essential ingredient of its success. Having this post did not however ensure that all those involved had sufficient time:

> *"There have been benefits in terms of creating the opportunities for joint working. There has always been a level of willingness to do this but whether they (the PSG members) can commit the time is another matter…they need someone to facilitate even things like setting a date for a meeting, arranging a venue and facilitating discussions in the meeting."* CHI team member)

In many respects, the CHI served to enhance existing relationships between agencies. As one PSG member said, the CHI *"played a really big part in just enhancing what was there already".* In other words, there was a strong foundation of joint and collaborative working in this area for the CHI to build upon. The Coordinator referred to the *"strong voluntary network that already existed"* and how *"personal contacts have evolved and grown"* from pre-existing relationships. These were especially well developed through the Children and Young Persons Services Forum as well as individual contacts. As one PSG member observed:

> *"…So we are not working in isolation to a North West Plan that does not bear any resemblance to what's happening across the city…it very much fits with it…but locally we have been able to take things forward in a particular kind of way …* "PSG member

PSG members and survey respondents generally felt themselves to have been well linked with other collaborative structures either before or since the CHI was established. This indicated a level of understanding of the community beyond their own agency and an appreciation of the value of working with others. However, a barrier to the development of the CHI identified by one survey respondent was that these links were not always as formal as they could be:

> *"Lack of any 'real' strategic links to local and national policy structures.*

*Constant changes in local structures (LHCC to CHSCP)." (*Survey respondent)

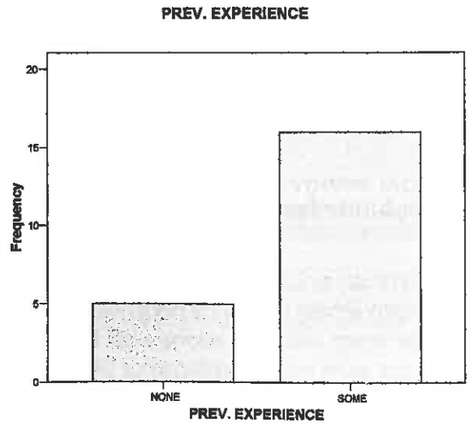
Regardless though of whether or not there was agreement amongst all on the effectiveness of links to existing structures, there was consensus that this was important.

A third aspect of the context in which this partnership developed was the high level of experience and knowledge of the neighbourhood evident from many of the participants in the evaluation. Survey respondents, PSG and team members were, in general, experienced professionals in general with a substantial collective number of years spent working in the neighbourhood. As noted elsewhere, survey respondents reported participating in up to four local groups. They belonged to an average of 1.5 groups.

Table 4: Membership of local groups

PUBLIC HEALTH TEAM	CHI STEERING GROUP	POSITIVE PARENTING GP.	CYP FORUM	EARLY YEARS SUB-GP	MEMBER OF OTHER GP	MONITORING GROUP- FSW
5	5	4	8	7	4	2
21%	21%	17%	35%	30%	17%	9%

Similarly, a majority (72%) of survey respondents had experience of collaborative work in this community related to the CHI and beyond as illustrated in the figure below.



There was a view among a number of participants, that the Maryhill and Woodside areas were not receiving an equal share of resources and that professionals working locally had a responsibility to address this:

"I've worked in different areas, and this area was quite particular in some kind of way in that it arose from a perceived disadvantage. There was a number of people who perceived great disadvantage in terms of services available for vulnerable families in this particular part of Glasgow." (PSG member)

An experienced group of professional activists working together in the area provided the impetus to set up the CHI. Individual personalities, an implicit trust in their professional competence by senior management, opportune timing, appropriate support and freedom to experiment often combine to bring project ideas into reality and this appeared to be the situation with the Maryhill and Woodside CHI.

6.2. Key Features of the Partnership.

In the literature, 'partnership' has many different meanings. Perceptions of this concept in the professional local community were therefore explored in respect of the CHI. The findings are discussed in the context of the key characteristics of successful partnerships as identified by Harrison et al (2003). These characteristics may be useful to the PSG as a guide for future discussion and development.

There was an assumption amongst all the professionals in the PSG and CHI team of a common understanding of partnership, even though this had never been tested or explored explicitly. A questionnaire completed by PSG members as part of the evaluation measured agreement in various dimensions of partnership working that has been found to be important in other partnership settings e.g. Evaluation of University-Community Collaboratives in Michigan 2005-06 and others. Considerable consensus was found among PSG members around items (individual statements) and dimensions (groups of statements representing the same idea) and this is a strength of this partnership. Making explicit shared meaning and terms would be an exercise that could assist the PSG towards further development. Differences of opinion may emerge during the process of clarification but this would be helpful to the process and adaptation to change.

Using Harrison et al's (2003) checklist of the key features of effective partnerships referred to in Section 1, comments about the CHI partnership are now explored.

The partnership involves more than two agencies or groups and includes the key stakeholders

There was agreement that the partnership involved a number of agencies but there were some reported professional gaps or limited contributions around the table at times and for various reasons generally related to remit and lack of time. Specifically, this related to representation from schools, housing, and social work. However, the partnership, at this point, does not target all key stakeholders e.g. local parents or the private sector are not involved,

Having common aims, acknowledging the existence of a common problem and having a shared vision of what the outcome should be.

Members of the PSG and CHI team perceived the partnership to be very much about sharing common aims based on an understanding of local issues and needs and having a *"shared vision"* about how to take this forward. Agreement was reached at the consultation seminar in 2002 that the way forward was to create the CHI and posts of Coordinator and Family Support Worker:

> *"..It was a much broader understanding of what affects children and creates disadvantage and vulnerability ...that was a very important element to it ...but it was a need to look at parenting support...need to look at all the issues in this area...poverty, drug misuse, alcohol misuse that affected children...but I think that gave it a real meaning to all the partners because everyone could see there was a meaning in that for their bit of the service or the service they provided."* (PSG member)

Having an agreed plan of action or strategy to address the problem

An action plan, alongside specific aims and themes had been agreed by the PSG, who regularly monitored progress in line with this. Also, an aspect of this evaluation was to test whether priorities agreed through the existing action plan were still considered relevant and valid. PSG members commented:

> *"Good communications built and maintained within partnership. Tasks always completed within reasonable/agreed timescales." (* PSG member identifying ingredients of success)

> *"A project approach to developing something that was not about bricks and mortar and that was about developing different ways of working across all the services"*

Acknowledging and respecting the contribution that each partner can bring

It was claimed that the partnership was characterised by *"mutual respect among all partners"*. This statement was one with which there was a high degree of agreement among PSG members.

Consulting with other relevant parties that are not part of the partnership

This was evident through the relatively high attendance by survey respondents to the consultation forum on the CHI (35%) and CHI Information sessions (43%). Both the Coordinator and the Family Support Worker referred to working relationships with a wide range of agencies, not all of which were represented at the PSG.

Exchanging information and having agreed communication systems

It was claimed there was a two-way flow of information. There was an implicit expectation that PSG membership meant both bringing information from the partner agency, taking information back and sharing with their own agency. However, this did not always meet the expectations of all PSG members as this comment by a PSG

member shows:

> *"The person on the PSG had not been making the links within their own organisation we expected".*

Sharing resources and skills

This is an integral thread to the work of the CHI and was mentioned as a strength by a number of survey respondents. Sharing skills and resources was evident in terms of the activities of the Positive Parenting Group as well as other activities organised by the CHI, such as joint training and the family support strategy.

Involving the taking of risks

The history of the project showed that there was some discussion about how money, which had become available to the LHCC (LIF), could be used in a more non-traditional way. This is not an easy choice as it likely to meet with resistance by some who hold other expectations of how money should be spent. One PSG member commented:

> *"It's quite an adventurous way to work together from different organisations in a very open and honest manner"*

Establishing agreed roles and responsibilities

A primary task for the PSG has been to decide on the roles and responsibilities of the Coordinator and FSW. However, the roles and responsibilities of individual PSG members, and of the PSG as a body, might not be clear to an outsider. There did appear to be, for example, an expectation that communication from individuals to their respective agency about the work of the PSG and vice versa was a two way process but clarification of this role and others (in writing) could be helpful and then open for discussion and review.

Establishing systems of communication between partners and relevant agencies

Establishing structures such as the PSG and the PPG, are evidence of establishing systems of communication as are the development of shared protocols which can initially be informal and clarified in writing, discussion, and reviewed following practice.

Protocol up to now has focused on the service component of the CHI – FSW referral. A protocol for joint training is being developed although there may be others that would make the CHI more widely accessible and open up the agenda e.g. role of the PSG and membership, participation, and making a contribution to partnership planning.

7. STRENGTHS AND BENEFITS

> *"The PSG has always supported ...the work of the CHI team ...and the meetings are always (so far at least) positive and constructive. What has been helpful is that the membership of the PSG has remained constant. This consistency has been helpful to me and I see this as a strength."* (CHI team member)

Opinions about the strengths of the CHI were collected through all the methods of data collection used in the evaluation. There was considerable consensus amongst all these sources about the strengths inherent to this Initiative. Three key themes emerged, which can be summarised as:

1. Positive qualities of the multi-agency relationships among partners
2. Impact of these relationships on service delivery and as part of wider collaboration
3. Skills of, and activities facilitated or provided by, the CHI team.

7.1. Positive Qualities of the Multi-Agency Relationships Among Partners

The CHI team and line manager reflecting on the positive qualities commented:

> *"On the whole people get along really well. There's a strong willingness to work together. I usually get a reasonable turnout at a meeting, which says something, and these are very constructive meetings. There's a positive feeling about partnership working in this area."*

> *"The cooperation experienced so far. People are ready and willing to work together and the process seems to be working well on the whole. Contacts are reciprocal. I personally find it rewarding working in this way, I like the different perspectives and find that refreshing."*

Findings from earlier chapters also support the importance of the strength of relationships found in the PSG and between partners. For example, PSG membership has remained relatively stable since inception and this provides an opportunity for relationships to develop, trust to build and consensus to be reached about aims, and activities. There appears to have been a change in only one member between 2004 and 2005.

The qualities of the relationships that were identified as a strength or positive feature of the CHI included the opportunity provided by the PSG to improve communication, increase awareness of each others' jobs, the flexibility of partners to adapt to change, the commitment of members which provided stability and continuity, the reciprocity and equality of relationship, honesty, openness and trust.

Although the questionnaire completed by PSG members at the start of the focus group was administered quickly to a small group, it still provided some interesting results and indicated consensus around the strengths and challenges of partnership working in the CHI. Findings from this questionnaire indicated that nearly all PSG members were more likely to strongly agree or agree with the majority of statements that described the functioning of an effective collaborative partnership. Only one respondent indicated slightly less, disagreeing with one and having a couple of other neutral responses. Individual total scores and individual average scores are given in Appendix 2, Table 2 *Individuals' total scores.*

The statements which showed the highest degree of consensus amongst PSG members are mostly around this theme of positive relationship between partners and is clearly inter-related with the second theme of the impact of these relationships on service delivery and as part of wider collaboration:

> *"Provided frequent opportunities for open and honest communication among partners".*
>
> *"This partnership was characterized by mutual respect among all partners".*
>
> *"Time was spent not only on project tasks, but also on building relationships among partners"*
>
> *"All partners understood that solving complex problems in the community requires a long-term commitment."*
>
> *"In this partnership, power was shared in an equitable manner"*

These views were not only held by PSG members but were reflected widely through other sources of data collection, including survey responses. Even though there may have been some overlap among participants, responses were consistent. For instance one survey respondent stated:

> *"Relationships based on honesty, openness, trust and practical benefits to local parents."*

7.2. Impact on Service Delivery and As Part of Wider Collaboration.

> *"I do it because I believe the benefits of this are there to the community as a whole…people benefit if we all provide services together."* (PSG member)
>
> *"Helps to tie together the different services and activities in the area. Helps us promote what we have to offer and find out what others have too."* (Survey respondent identifying strengths)

A focused, task-centred approach was an integral feature of the CHI partnership – this was related to the positive views held about the partnership and its impact and illustrated by the following comment:

"Project planning ….kept it quite focussed…everyone had a stake in it, an investment in it and there was a meaning to it and I think that was tremendously important. "

"I think this particular initiative has always had in mind the benefits that it would bring to local families and local population, it's always been delivering tangibles ..information day, posts" (PSG member)

Good working relationships at this local level were perceived to have had an impact on service delivery because gaps were identified, good practice highlighted, duplication avoided and good informal working relationships helped avoid bureaucratic barriers that often build between services. It was further claimed that these factors all helped make services more direct and accessible to local people.

The links of the CHI through PSG membership are important in terms of being part of wider collaborative efforts that also involve local residents and parents. A couple of PSG members elaborated on this and described how the CHI emerged from the work of a wider forum, the Children and Young People's Forum and also that it fit with the priorities being set at wider service and geographical areas:

"Glasgow City Council for example, have a Children and Family Services Plan, which is a joint agency plan and there are various strategic groups linked to that…looking at how services are developing in this city in line with the priorities that have been identified…and early years have a very high priority within that planning structure….and they have set up mechanisms for consulting with parents that will help to inform that process as well…so there's the bigger picture in how we fit in relation to that and so there are opportunities and mechanisms for that to happen".

"That's true we do fit into the overall structures and I think early on one of the advantages …for the forum initially was a realisation that there was some overlap in these two different structures: Child Care Strategy and Children Services Planning, we've fed into both and that's been an advantage…"

7.3. Skills and Activities of Team

Survey respondents highlighted the skills of, and activities facilitated or provided by, the CHI team as a major strength:

"People who work in the project are extremely motivated."

"Good appointments of FSW and Co-ordinator"

"Skills and knowledge of the Health Coordinator"

Various participants in the evaluation highlighted the attributes of the CHI team as its strength. The achievements of the team under the main themes were all highlighted as tangible areas of productivity and strength. The profile of participants in the evaluation included representation from ethnic minority groups, indicating

engagement with the CHI and responsiveness to diverse needs in the local community.

The PSG identified the importance of having a dedicated post to take forward the joint agenda and also, with very high consensus, through the questionnaire, they strongly agreed with two statements, which likely applied to CHI staff:

"This partnership has a person who was skilled at generating consensus."

"This partnership has a person who was skilled at project management".

8. PERCEIVED IMPACT

"No one agency works in isolation. Partnership and collaboration produce better outcomes for the population we serve." (Survey respondent)

Outcomes are measurements of change – increases, decreases or no change - in knowledge, attitudes or behaviours related to objectives. In this instance, a survey was used to find out more about perceptions of the potential impact (outcomes) of the CHI. A retrospective pre-test measure was distributed to those who had worked with the CHI in some capacity. A total of 21 individuals responded to the question on outcomes. Change was assessed along nine dimensions related to the CHI aims:

1. **Contribution** to child and parenting policy & planning.
2. **Coordination** of agencies that support families.
3. **Knowledge** of agencies involved in child & family work.
4. **Understanding of the roles** of others involved in family work.
5. **Regular meeting** with representatives from other agencies.
6. Well **coordinated and accessible information** for parents.
7. Local **joint training** on family work.
8. How to **make a referral for family support**.
9. The availability of **quality family support**.

8.1. Achieving General Aims

Positive outcomes were found by all respondents in each of these nine areas. The areas in which change was found differed and are detailed in the following Table 5.

Table 5: CHI Related Outcomes

	BEFORE		AFTER		OUTCOME
CHI related statements	Mean	Std. Deviation	Mean	Std. Deviation	
1. I regularly contribute to local policy and planning groups on children's wellbeing and parenting.	1.6	0.7	2.1	0.7	
2.Support to children and families is well coordinated across the different agencies in the local area.	1.5	0.6	2.3	0.6	
3. I know which agencies and individuals are involved locally in the field of child and family wellbeing and family support.	1.9	0.8	2.5	0.6	
4. I understand the roles of others who work locally in the field of child and family wellbeing and family support.	1.8	0.8	2.4	0.6	
5. I regularly meet, formally or informally, with other local workers from other agencies with common interests.	1.9	0.8	2.4	0.6	
6. There is well coordinated and accessible information for local parents.	1.3	0.5	2.1	0.6	
7. I have opportunities to participate in local joint training events on child and family well being and parenting topics.	1.4	0.5	2.0	0.7	
8. I know who and how to make a referral when there is a need for family support to help families with homemaking skills, raising awareness of benefits and helping them to access local services and facilities.	1.6	0.7	2.5	0.7	
9. There is quality support available to individual families on homemaking skills, raising awareness of benefits and helping them to access local services and facilities.	1.3	0.5	2.3	0.6	

Knowledge and coordination of quality family support services and the coordination and accessibility of information for parents each showed the largest positive change linked to the CHI (as indicated by differences between the mean scores reported by respondents before and after the establishment of the CHI).

The extent of contribution to local policy and planning and to regular meeting with

other workers also showed a positive change but to a smaller extent than found in other areas. However, these were areas that had relatively high activity before the establishment of the CHI so there was less potential for growth.

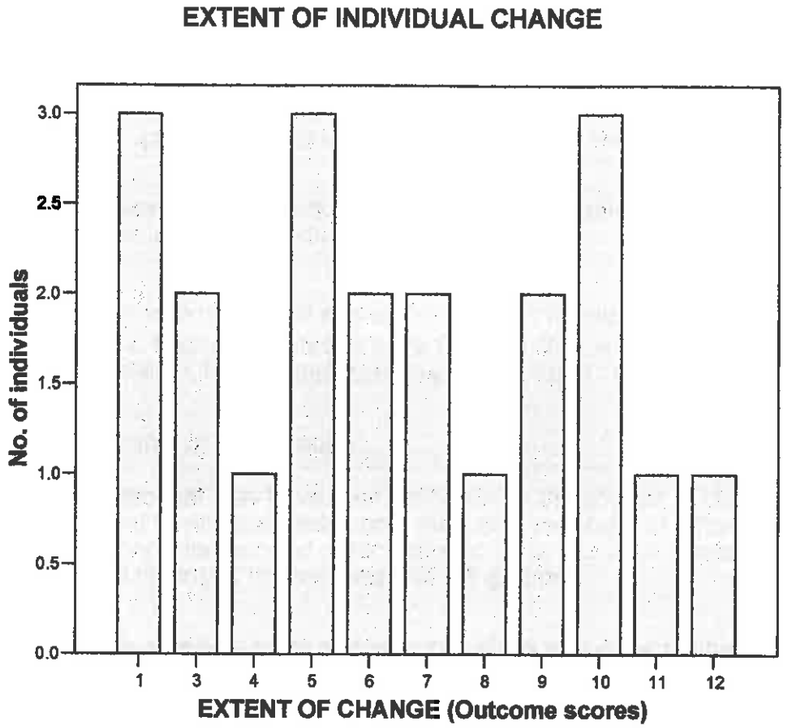
Further, it should be noted that before the CHI was established, none of the respondents reported that there was 'lots' of coordination or access to quality family support, joint training or coordinated information for parents. However, this changed as a result of the CHI activities and between one quarter and a half of all respondents now thought that there was 'lots' (See Frequency Tables Appendix 1).

According to those who responded to the questionnaire, the CHI had been successful in achieving its general aims and objectives.

8.2. Variation between responses

There was some variation in the way individuals reported change. This is not surprising, given the variation in the backgrounds and experience amongst respondents. Each respondent was given a score according to the amount they reported change i.e. if they thought that there was 'little' (1) coordination before the CHI but 'lots' (3) after it had been established, the score was 2. If they reported 'some', after the CHI was established then the score was 1 and similarly if no change was reported between before and after the CHI then the score was 0. All items were then added to give each individual an "Outcome Score" with a possible range from 0 (indicating no change) - 18 (maximum change).

The graph below shows that the minimum score was 1 and the highest score was 12 with an average score of 6.3. All respondents identified some change although two respondents did not complete this part of the survey and so are excluded from the calculation. The total number of relevant responses was 21. Since the group had a number of highly experienced individuals and therefore the starting point for change was higher, this average score is as anticipated and is satisfactory especially since all individuals reported change of some kind in one or more of the dimensions.



This sample size was small, making it difficult to determine statistical differences between individuals in terms of their characteristics, such as, which sector they were employed, previous experience of collaboration or length of time spent working in the locality. These characteristics may be important in terms of the general success of the project but were not apparent in statistical analysis of individual differences between those with small (1-6) outcome scores and those with larger (7-12) scores (See Appendix Z). Further exploration of these characteristics, however, may have identified outcome differences between individuals.

8.3. Exploration of Other Characteristics and their Relationship to Impact

8.3.1. Participation in CHI activities

When considering the extent of change reported by survey respondents it is also worth looking at the extent of participation in CHI activities. Nearly a third (30%) of all respondents reported that they had not participated in any of the CHI related activities although a majority (70%) had participated in up to three activities. (For more information see Chapter on Aims & Themes). These are included in the table below.

Table 6: Participation in CHI Activities

Consultation seminar	Information session	Storysacks	Handling child behaviour	Baby Massage	Joint Work - FSW	OTHER
8	10	4	3	0	4	2
35%	43%	17%	13%	0%	17.%	9%

The information session on CHI work (43%) and the consultation seminar (35%) were both attended by the largest proportions.

Although the sample size was small and so conclusions should be cautious, it was found that those who had participated in more CHI activities were statistically significantly more likely to have higher outcome scores (sign –test)

8.3.2. Membership of local groups

Another characteristic that may have been influential in the amount of change could have been the extent to which professionals were also members of other local groups. Most respondents reported participating in up to four local groups (See Table 4 earlier) and belonged to an average of 1.5 groups.

Although the sample size was small and so conclusions should be cautious, it was found that those who were members of a range of other local work groups were also statistically significantly more likely to have higher outcome scores (sign –test).

These results about participation and membership may be indicative of a networking approach to work that either results or underpins a more positive change in attitudes, skills and behaviour from professionals involved.

9. CHALLENGES AND GAPS

The challenges and gaps identified by participants fell into three main categories:

* Participation
* Change and communication
* Time & Money

9.1. Participation

Although a number of agencies were identified as participants, contributions and commitment did not always match expectations of other members and gaps were identified. The absence of local parents, families, volunteers and community members in the PSG was raised by a number of participants, although it was also felt that the CHI was connected to these groups through other contexts or planning structures. Also the following gaps were identified:

> *"Housing was involved in planning the original seminar but they aren't involved in the PSG now. This could be a result of the fragmentation of the housing sector".*

> *"Some agency links.....have been disappointing and I feel this could be better. The person on the PSG had not been making the links within their own organisation we expected. There's an enthusiasm and willingness....but referrals to FSW are slow so there are some barriers."*

> *"....partnership working extends beyond perhaps the Steering Group ...and that entails a certain amount of commitment from all the partners to be involved with this process ...and especially as currently there are so many changes to the structures within City Council itself....."*

In addition, survey respondents identified the lack of input from social work and education, in terms of schools and further education. PSG members supported this although a way of addressing it was identified by using the networks open to members. This did not always appear to have worked successfully, in view of the comments about commitment and communication:

> *"...but the people around this table do have contacts, for example people around here sit on the Learning Communities which cover all of these and we do have contacts with local colleges, whilst we might not have them around the table, we do know how to engage them if we need to engage them"*

In some cases this may have been due to differences in priority that some could give to the tasks of the PSG in view of the balance of their workload and decisions were being made about the priority that was given to the CHI.

There was a sense that membership of the partnership was open to all:

> *"There is always a place for including others but you have to look at the bigger picture to see if it would help."* Survey respondent

> *"Membership of the PSG is open; they are not sitting there with the door closed so if there's someone not there they'll be invited in."* CHI team member

However, having a policy of openness is not the same as actively seeking participation although it is recognised that with any initiative there is a need to produce concrete 'deliverables' such as specific posts, group and event creation.

9.2. Change and Communication

There is concern about the extent to which external changes will affect the CHI and how much the CHI can have an influence on these changes. In order to be influential the CHI needs to be strong and effective and manage its own internal challenges, such as managing the implications of organisational change in social work or frequent management changes in the Health Board.

External links to existing outside structures need to be strong:

> *"This is a localised relatively small Initiative and one challenge or gap is perhaps how to hook it into the strategic planning process. Should the PSG have a higher profile within the LHCC and the emerging CHP than it does at present? It needs a profile in order to develop and plan and see the bigger picture in planning children and families work. Still needs to be supported by ongoing funding".* (CHI team)

> *"Lack of any 'real' strategic links to local and national policy structures. Constant changes in local structures (LHCC to CHSCP)"*

Whether or not there was agreement amongst all on the existence of effective links to existing structures, there was consensus that this was important. Potential changes to local structures, including the reorganisation of Social Work and the establishment of the CHP also tended to be viewed as a potential limitation. For instance the CHI line manager commented:

> *"There could be a period of unsettlement as the CHP establishes itself. There will be a Head of Planning and Health Improvement/Promotion and it will depend on how they want to lead their role and their approach but I would hope they will listen to people and go in to find out about the projects rather than try and change them from day one."*

There appears to be some ambivalence about the breadth and extent of openness and a reliance on PSG members and the CHI team to use their networks to ensure effective communications. It is important then that these commitments are fully appreciated and followed through by PSG members. Communication between partners on the whole was perceived as effective:

> *"Compared with other inter-agency networks I think it works better than most.*

There's not that much rivalry between the partners and that helps." (CHI line manager)

"Not on the PSG, at least nothing overtly. Maybe that's not a good thing and perhaps we're only scratching the surface!" – (CHI team member)

As an aspect of effective communication, conflict resolution was identified as an area where there was little information. There was little agreement with the PSG questionnaire statement on this topic in relation to the item *'This partnership effectively resolved conflicts between partners.'*

However, this does not necessarily appear to be because there was a lot of underlying conflict but the absence of open disagreement, either because there had in fact been none, it is avoided or it was suppressed in order to achieve tasks around much of the work. In any case the group did not explicitly note any unresolved challenges. Lack of experience with conflict resolution however does mean that no strategy had been identified to deal with this should it arise. It may be that the PSG develops strategies to avoid conflict rather than confront as this quote indicates:

"...- disappointment that the social work link hasn't made things happen. We're already addressing these shortcomings/weaknesses through for instance we have recently established links with the SW Changing Children's Services Fund Group".

9.3. Time & Money

Many of the respondents when talking about limitations or barriers to the CHI and its development tended to refer to a lack of time and money:

"People's time is limited because of their workload on a daily basis." (CHI team member)

"Making enough time over caseload work. Often social work are not represented because of their workload in the monitoring group." (Survey respondent)

The lack of resources appeared as a common theme from all the evaluation participants. For example, in the PSG questionnaire, the topics primarily identified as ones where there was less agreement related to the adequacy of time and resources. These were important especially when it is noted that lack of time had implications for participation and extending understanding amongst the group of the local and agency contexts. Time may also have been a factor in relation to conflict resolution discussed above.

The relevant statements on these resources from this questionnaire where there was little agreement with the statements included:

- *'This partnership had sufficient resources to do the work at hand.'* Time & money were identified as lacking by a couple of respondents.

- *'My partner took the time to help me understand the context within which*

he/she operates.'

- *'In this partnership, sufficient time was set aside for partners to gain a deep understanding of the community with which they were working.'*

9.4. Other gaps

Less than half of the survey respondents identified gaps but since some of these are practical they are included here for future reference. The following practical gaps and suggestions were offered:

1. More joint training initiatives.
2. Would like to see them attend Health Visitor meetings on a regular basis to improve communication channels.
3. Believe it to be under resourced. Initial plans to develop services highlighted potential to expand in the future around four key themes in project planning.
4. More family health support workers needed.
5. Booklet with all services being offered.
6. Dedicated resources (staff and funding) to develop joint training work and community development work with local parents/families.
7. Linking Pre-5s to appropriate physical activity sessions at community and mainstream facilities
8. Guest speakers on health agenda and also education and social work.
9. More communication from CHI necessary to inform/remind practitioners of services.

10. IDEAS FOR FUTURE DEVELOPMENT

Evaluation participants made several suggestions for the development of the project, although there was an understandable tentativeness because of the uncertainties about what the CHSCP might bring. As it was believed that the initiative was already having a significant impact on partnership working in the area, many suggestions for future development were concerned with consolidating and building upon existing arrangements. Within the PSG there was a common perception that the current action plan remains relevant.

10.1. Consolidation of existing work

Much of the planned development centred around consolidating existing work, including further developing parental support, for example with fathers and young parents while linking to existing structures to do so. Survey respondents generally called for 'more of the same' given the perceived success of the existing work:

> *"By continuous funding the project would be able to develop the good work already started."*

> *"Develop the role of the FSW and increase the team capacity by recruiting more".*

> *"The family health worker role is valuable, however she is only one person and there would appear to be a lot of need".*

It was hoped that the initiative *"continues to develop and achieve its goals and objectives"* and that *"the network strengthens what it has and widens its membership"*. One survey respondent suggested that the CHI team could *"come out and do talks to the area teams or other agencies"*.

The current action plan demonstrates the PSG's intention to develop the CHI in terms of each of the main themes: that is, to consolidate the FSW role, to continue to develop positive parenting activities and events, local consultation, organise further joint training and so on. This is particularly in terms of taking forward work under less developed themes such as information for parents.

A need for information packs for parents and others to be made available providing contact information and location of each service was identified. However, given the potential magnitude of the task, the PSG and CHI team envisaged this being achieved through broader partnership networks rather than by the CHI itself, although through participation in these networks the CHI Coordinator would clearly play a part in progressing this idea. Related to this theme, the Coordinator saw merit in investigating a local *"drop-in centre for parents using a shop front"* similar to another initiative elsewhere in Scotland. It was thought that the community health project rather than the CHI would develop this kind of project.

A key point made by a number of participants was that the strength of the relationships between partners and agencies involved in the CHI, and its

achievements so far should provide a *"sound foundation"* for being flexible and adapting effectively to change. PSG members commented:

> *"Good preparation for that (change to CHSCP) because the relationships will move into the new arrangements …*
>
> *"..Because if the relationships that have been developed between different partners are strong enough – and I believe that they are strong enough in this area – we can then adapt to the changes that are coming you know."*

10.2. CHSCP - Threat or Opportunity?

It was less clear to the evaluation participants how the imminent changes in management and service structures when the CHSCP is fully implemented will affect the organisation and operation of the CHI. Nevertheless, it was hoped that the CHI would continue to *"flourish in the area"*, and even that the principles *"will be rolled out to the whole of Glasgow"*. It was unclear what the profile of the CHI would be within the new structures:

> *"Should the PSG have a higher profile within the LHCC and the emerging CHP than it does at present? It needs a profile in order to develop and plan and see the bigger picture in planning children and families' work. It still needs to be supported by ongoing funding."* (CHI team member)

And even though there was potential to raise the profile of the CHI, there were threats to the future of the CHI from the development of new management structures. How this worked in practice would to some extent depend upon the approach adopted by the new heads of service and planning.

It was suggested that boundary changes would continue to play a part as one of the challenges as the boundaries of the Glasgow CHPs have only recently been agreed. That *"big chunks of Maryhill and Woodside are now going to the West CHP"* while health improvement would be the responsibility of a team based in the North East CHSCP could have an impact on the organisation and implementation of a future CHI.

It was optimistically suggested that there was *"potential for development or enhancement"* for the CHI within the new structures. Some felt that the CHI could fit better with health improvement agenda for Scotland being developed through CHPs and that it could be *"a much better feature"* in this than it has been under the LHCC. It was unclear though where the CHI would fit within the new organizational structure and whether the CHI would continue. For instance, might the FSW post be linked in the long term into a multi-disciplinary team, such as Starting Well or some other Team, and the coordination role of the CHI located elsewhere within the organisation?

10.3. Increase parental participation

An area for development identified by a couple of survey respondents and CHI team members was in terms of involving parents as partners in the CHI. There has been discussion within the team, the PSG and other local partnership structures about the best and most appropriate ways to develop a more direct role for parental participation in planning and developing services. It was observed that *"there's not a lot of parent involvement"*, and a sense from some participants that *"it would be good to involve parents"*. The Coordinator commented:

> *"They (parents and community representatives) haven't so far had direct involvement in influencing how the Initiative takes shape. The professionals involved with the Initiative have played an advocacy role representing parents' interests. We're looking just now at how to get more feedback from parents through the FSW's role." (CHI team member)*

It was argued that professionals were well grounded in the issues and concerns of local communities through their day-to-day work and participation in other planning networks. However, there was room for considering how to involve parents more directly, especially given that the purpose of local Public Partnership Forums (PPFs) is about strengthening relationships between health services, community groups and individuals as well as with other partners. One of its roles will be to engage local service users, carers and the public in discussions about service improvements, and another will be to support wider public involvement in planning and decision-making.

10.4. Time and money

A number of participants identified developments that would, in an ideal world, be supported by additional funding, a more secure funding base and more time. Although as evaluators, it was not possible to identify specific costs of the initiative. Ideas included resourcing a men's health post, an additional family support post, developing work with fathers, engaging with the local community, evaluation of the initiative in 2 or 3 years time and research on family's views.

It was acknowledged by the PSG that the CHI is under-resourced as it is but suggestions to address this included the exploration of part-time secondment of a Community Development worker for a year and whether the CHSP might offer any funding opportunities in these areas.

11. DISCUSSION AND CONCLUSIONS

> *"What we've recognised is that it did come from something before and it has developed beyond in some respects in that probably most people in this Steering Group meet in different groupings ...looking at different developments or spin offs, or things that interconnect to what we do here.."* – PSG member

As the quotation above suggests the Maryhill and Woodside Child Health Initiative, the focus of this evaluation, was built upon existing professional networks. In large part, the CHI has focused a network of professionals into a partnership, which has co-ordinated services to address issues of overlap, duplication and perceived gaps in service provision towards common outcomes as conceptualised by Frost's (2005) ladder of partnership.

This evaluation addressed two main areas in a short timescale: it assessed progress and development of the CHI, and considered issues for future planning. Accordingly, the evaluation consulted with those who knew the initiative best as well as examining written reports. In respect of these perspectives, the findings affirm the current aims and themes of the CHI, especially in terms of coordination and family support. These also corresponding well with professionals' own priorities and perceived local needs.

In terms of measurable outcomes, knowledge and coordination of quality family support services and the coordination and accessibility of information for parents showed the largest positive changes resulting from the CHI partnership. The literature on good practice underlines the importance of such coordination to the delivery of flexible and effective services and the benefits to children and families.

Significant to the enterprise was the recognition that collective action can achieve more than a single agency, acting alone. The majority of local professionals involved in this evaluation appeared to be positively predisposed to the idea of networking and partnership working. Success of a partnership therefore can be both attributable to individual characteristics and predisposition of all those involved, and to the local context as providing a fertile environment in which partnership working can flourish. In this respect a local consensus that an initiative focusing on child and family health was a 'good thing'; that to an extent positive relationships and structures already existed between relevant professionals; the high level of experience and knowledge of the neighbourhood among local professionals; and a drive to address identified inequalities, combined to provide the impetus to create the CHI.

In summary, the CHI was found to have been successful in terms of:

* The positive qualities of the relationships among partners where the PSG provided a forum with stability and continuity to support the development of professional relationships essential to multi-agency, coherent service delivery
* Facilitating a focused, task-centred approach helped solidify commitment and supported practical developments

* The wider context of collaborative working beyond the boundaries of Maryhill and Woodside and the health focus of this particular initiative, and
* Having a skilled and experienced team and also the dedication of a full-time post to coordinate and take forward the joint collaborative agenda.

Overall therefore, the CHI seems an appropriate response to identified local concerns and issues, which is supported by the findings from this evaluation. Several evaluation participants asserted that the CHI was "needs led" and this was identified as one of its strengths. To the extent that the views were shared by the professionals involved in terms of community needs and the responses required to meet these needs, this is valid. However, there could be some debate about whether professional perceptions of need and solutions are exactly the same as residents' perceptions.

Looked at against definitions of partnership from the literature, the CHI clearly has many features of successful partnerships (Harrison et al, 2003). Further, in evaluating the extent of progress in developing this partnership initiative, it could be seen to be operating at around level 2-3 on a scale from 1 to 4 conceptualised by Frost (2005) from cooperation at level 1 through to merger/integration at level 4.

The CHI is difficult to describe in tangible terms and some of its aims are global and difficult to measure. This is due in part to the nature of coordination and developmental and coordination tasks, and these have not been quantified beyond the activities achieved and planned under main aims and themes in the action plan. Yet this is a contribution that the partnership could explore.

In terms of future implications, the strong foundation of professional partnership and service co-ordination should ensure the CHI is flexible and adapts to change in the context of new management and service structures. One shortcoming identified by the evaluation was in the area of community and parental participation and involvement. The existing commitment and drive of those involved in the CHI and what has been learned through collaborating in an effective professional partnership, should enable the initiative to evolve and embrace wider participation of local parents and other sectors. The new CHSCP structure may offer new possibilities for developing beyond a professional partnership to something that is community or parent driven.

The new CHSCP does have direct implications for the style of work, how the initiative is organised and serviced, staffing and resources allocated to this work, where it should be based. All of which will need to be decided locally. However, it is hoped that the findings of this evaluation will provide a constructive base for considering such issues.

12. REFERENCES & FURTHER READING

Consultation Seminar 6 June 2002, *Improving the health and social needs of local children and families: making the best use of new funding from Maryhill & Woodside LHCC*, Final Report and Proposal.

Fairley, A. (2004), *Audit of Childcare Services in North West Glasgow. Report to North West Children and Young Persons Services Forum,* Maryhill Children and Young Persons Services Forum.

Fairley, A. (2001), *Audit of Childcare Services,* Maryhill Children and Young Persons Services Forum.

Frost, N. (2005), *Professionalism, partnership and joined up thinking. A research review of front-line working with children and families,* Research into Practice No 8. Devon: Blacklers and University of Sheffield.

Harrison, J., Mann, G., Murphy, M., Taylor, A., and Thompson, N. (2003), *Partnership Made Painless. A joined-up guide to working together,* Dorset: Russell House Publishing.

Julian, D. (1997). The utilization of the logic model as a system level planning and evaluation device. *Evaluation and Program Planning*, 20 (3), 251-257.

Julian, D., Jones, A., & Deyo, D. (1995). Open systems evaluation and the logic model: Program planning and evaluation tools. *Evaluation and Program Planning*, 18 (4), 333-341.

McEwan, K., & Bigelow, D. (1997). Using a logic models to focus health services on population health goals. *The Canadian Journal of Program Evaluation*, 12, 167-174.

Scottish Executive Health Department, (2005), *Patient Focus and Public Involvement: Establishment of the Scottish Health Council,* Letter and Annex 1 & 2.

Scottish Executive Health Department, (2003), *Partnership for Care*, Edinburgh: Scottish Executive.

Scottish Executive, (2004), Protection Children and Young People: Framework for Standards, Edinburgh: Scottish Executive.

Scottish Executive, (2001), *Patient Focus and Public Involvement*, Edinburgh: Scottish Executive.

Scottish Executive, (2000), *Our National Health: A plan for action, a plan for change,* Edinburgh: Scottish Executive.

Scottish Office, (1997), *Designed to care. Renewing the National Health Service in Scotland,* Edinburgh: The Stationery Office

Stanley, J. (2005), *From the Evaluation of Partnerships to Partnerships for*

Evaluation, Paper delivered at UK Evaluation Society Conference, Manchester 1-2 December 2005.

Taylor-Powell, E., Rossing, B. & Geran, J. (1998) *Evaluating Collaboratives: Reaching the Potential.* Madison, WI: University of Wisconsin, Extension.

Tennyson, R. (1998), *Managing Partnerships: Tools for Mobilising the Public Sector, Business and Civil Society as Partners in Development,* Prince of Wales Business Leaders Forum.

United Way of America. (1996). *Measuring program outcomes: A practical approach.* Arlington, VA: United Way of America. http://www.unitedway.org/outcomes/

Weiss, C. (1998). *Evaluation, 2nd Edition*, Chapter 3. Upper Saddle River, NJ: Prentice Hall.

13. APPENDICES:

13.1. Appendix 1: Perceived impact:

Changes in participant perceptions of opportunities (coordination, information for parents, quality family support) before and after the establishment of the CHI.

COORDINATION - BEFORE

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	LITTLE	12	52.2	54.5	54.5
	SOME	9	39.1	40.9	95.5
	LOTS	1	4.3	4.5	100.0
	Total	22	95.7	100.0	
Missing	9.0	1	4.3		
Total		23	100.0		

COORDINATION - NOW

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	LITTLE	2	8.7	9.1	9.1
	SOME	12	52.2	54.5	63.6
	LOTS	8	34.8	36.4	100.0
	Total	22	95.7	100.0	
Missing	9.0	1	4.3		
Total		23	100.0		

INFO FOR PARENTS - BEFORE

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	LITTLE	15	65.2	68.2	68.2
	SOME	7	30.4	31.8	100.0
	Total	22	95.7	100.0	
Missing	9.0	1	4.3		
Total		23	100.0		

INFO FOR PARENTS - NOW

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	LITTLE	3	13.0	13.6	13.6
	SOME	13	56.5	59.1	72.7
	LOTS	6	26.1	27.3	100.0
	Total	22	95.7	100.0	
Missing	9.0	1	4.3		
Total		23	100.0		

QUALITY SUPPORT - BEFORE

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	LITTLE	14	60.9	66.7	66.7
	SOME	7	30.4	33.3	100.0
	Total	21	91.3	100.0	
Missing	9.0	2	8.7		
Total		23	100.0		

QUALITY SUPPPORT- NOW

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	LITTLE	2	8.7	9.5	9.5
	SOME	10	43.5	47.6	57.1
	LOTS	9	39.1	42.9	100.0
	Total	21	91.3	100.0	
Missing	9.0	2	8.7		
Total		23	100.0		

Perceived impact of the CHI in terms of number of years working locally.

YEARS WORKED LOCALLY	OUTCOME SCORES		Total
	SMALL (1-6)	LARGE (7-12)	
6+ years	2	3	5
	18.2%	33.3%	25.0%
<1 - 5 years	9	6	15
	81.8%	66.7%	75.0%
Total	11	9	20
	100.0%	100.0%	100.0%

Perceived impact of the CHI in terms of previous experience of local collaborative/partnership working

PREV. EXPERIENCE OF PARTNERSHIP/COLLABORATIVE WORK IN THE LOCALITY	OUTCOME SCORES		Total
	SMALL (1-6)	LARGE (7-12)	
NONE	2	3	5
	22.2%	30.0%	26.3%
SOME	7	7	14
	77.8%	70.0%	73.7%
Total	9	10	19
	100.0%	100.0%	100.0%

Perceived impact of the CHI in terms of number of sector of employment

SECTOR EMPLOYED	OUTCOME SCORES		Total
	SMALL (1-6)	LARGE (7-12)	
NHS	6	6	12
	54.5%	60.0%	57.1%
LA	3	1	4
	27.3%	10.0%	19.0%
VOL	2	3	5
	18.2%	30.0%	23.8%
Total	11	10	21
	100.0%	100.0%	100.0%

13.2. Appendix 2: PSG Questionnaire Results

RESULTS (n=7)

To what extent do you agree with the following statements?
(For each question, circle the correct number)

Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
1	2	3	4	5

- The higher the **mean** then, in this instance, indicative of greater group consensus.
- **Ranks** means scores from (highest – strengths?) 1 2 3 4 5 6 7 (lowest – challenges?)

Table 1 Average scores

	Average	Rank
This partnership:		
1. Provided frequent opportunities for open and honest communication among partners.	4.6	1
2. Provided sufficient time and opportunity for trust to develop among partners.	4.1	4
In this partnership:		
3. Time was spent not only on project tasks, but also on building relationships among partners.	4.4	2
4. Partners worked to maintain the continuity of the partnership over time.	4.3	3
5. All partners understood that solving complex problems in the community requires a long-term commitment.	4.4	2
6. In this partnership, sufficient time was set aside for partners to gain a deep understanding of the community with which they were working.	3.7	7
7. Partners understood and accepted that universities and community-based organizations have somewhat different values, priorities, and interests.	3.9	6
8. My partner took the time to help me understand the context within which [illegible]	3.7	7
9 In this partnership, power was shared in an equitable manner.	4.3	3
10. Resources were shared in an equitable manner in this partnership.	4.4	2
11. All partners participated equally in major decisions.	4.1	4
If you disagreed with this statement, was it primarily due to:		
a. A lack of interest or participation on the part of some members	One agreement (4) with this statement	
b. "Behind the scenes" actions of some members	One neutral (3)	
c. Forceful participation of some members	One neutral (3)	

12. Decisions that the group made were usually implemented.		4.1	4
13. This partnership had sufficient resources to do the work at hand.	Disagree - time - funding	3.4	8
14. This partnership effectively resolved conflicts between partners.		3.7	7
15. We reached a consensus on our group's agenda.		4.1	4
16. Roles, norms and processes for the partnership were established with the input and agreement of all partners.		4.1	4
17. Partners accomplished tasks in a timely manner.		4.1	4
18. This partnership had a person who was skilled at generating consensus.		4.3	3
19. This partnership had a person who was skilled at project management		4.6	1
20. Partners had the authority to make decisions on behalf of the organizations they represented.		4.0	5
21. Partners were flexible and willing to compromise.		4.1	4
22. Partners were willing to reflect on or challenge their attitudes, assumptions, or beliefs.		4.0	5
23. This partnership was characterized by mutual respect among all partners.		4.4	2

Any comments about the 'essential ingredients' you found when building this partnership?

- *The time that was spent in developing the partnership and the absence of any real timescale pressures = mainstream development.*
- *Shared vision*
- *Focused plan & planning process*
- *Good communications built & maintained within partnership. Tasks always completed within reasonable/agreed timescales.*

Any comments about barriers you have faced when building this partnership?

- *My own group had difficulty initially accepting the concept of the home support worker.*
- *Initially there was an assumption in the LHCC that the funding could be used for nursery nurse posts to support public health nurses -- with no cognisance of the need for a partnership approach to improve child health & inequality.*
- *Solely my own -- my remit is wider than pre5s and this caused constraints e.g. at the joint steering group meetings*
- *No barriers*

Table 2. Individuals' total scores

From the survey of PSG members scores were assigned to each person by summing responses given to each statement (range of 1 to 5 on each response). Maximum possible score = 115, minimum possible score = 23.

Individuals' total score	Individuals' average score
107	4.6
104	4.5
96	4.2
95	4.1
94	4.1
93	4.0
90	3.9

13.3. Appendix 3: PSG Questionnaire

Maryhill & Woodside Child Health Initiative
Partnership Steering Group Questionnaire – October 2005

To what extent do you agree with the following statements? (For each question, circle the correct number)

	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
This partnership:					
24. Provided frequent opportunities for open and honest communication among partners.	1	2	3	4	5
25. Provided sufficient time and opportunity for trust to develop among partners.	1	2	3	4	5
In this partnership:					
26. Time was spent not only on project tasks, but also on building relationships among partners.	1	2	3	4	5
27. Partners worked to maintain the continuity of the partnership over time.	1	2	3	4	5
28. All partners understood that solving complex problems in the community requires a long-term commitment.	1	2	3	4	5
29. In this partnership, sufficient time was set aside for partners to gain a deep understanding of the community with which they were working.	1	2	3	4	5
30. Partners understood and accepted that universities and community-based organizations have somewhat different values, priorities, and interests.	1	2	3	4	5

	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
31. My partner took the time to help me understand the context within which he/she operates.	1	2	3	4	5
32. In this partnership, power was shared in an equitable manner.	1	2	3	4	5
33. Resources were shared in an equitable manner in this partnership.	1	2	3	4	5
34. All partners participated equally in major decisions.	1	2	3	4	5
If you disagreed with this statement, was it primarily due to:					
a. A lack of interest or participation on the part of some members	1	2	3	4	5
b. "Behind the scenes" actions of some members	1	2	3	4	5
c. Forceful participation of some members	1	2	3	4	5
35. Decisions that the group made were usually implemented.	1	2	3	4	5
36. This partnership had sufficient resources to do the work at hand.	1	2	3	4	5

*If this partnership **did <u>not</u> have sufficient resources** to do the work at hand, what kinds of resources were missing?*

37. This partnership effectively resolved conflicts between partners.	1	2	3	4	5
38. We reached a consensus on our group's agenda.	1	2	3	4	5
39. Roles, norms and processes for the partnership were established with the input and agreement of all partners.	1	2	3	4	5

	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
40. Partners accomplished tasks in a timely manner.	1	2	3	4	5
41. This partnership had a person who was skilled at generating consensus.	1	2	3	4	5
42. This partnership had a person who was skilled at project management.	1	2	3	4	5
43. Partners had the authority to make decisions on behalf of the organizations they represented.	1	2	3	4	5
44. Partners were flexible and willing to compromise.	1	2	3	4	5
45. Partners were willing to reflect on or challenge their attitudes, assumptions, or beliefs.	1	2	3	4	5
46. This partnership was characterized by mutual respect among all partners.	1	2	3	4	5

Any comments about the 'essential ingredients' you found when building this partnership?.....

.....

.....

.....

Any comments about barriers you have faced when building this partnership?.....

.....

.....

.....

REF		

13.4. Appendix 4: Postal Questionnaire

Evaluation of Maryhill and Woodside Child Health Initiative 2005

All information is for evaluation purposes only and will be **CONFIDENTIAL**. Individual information or views will not be shared in a way that could identify you. If you prefer not to answer any specific questions, that is fine. If you have any concerns or questions, send an email to Dr. Rosalind Kirk roskirk@comcast.net

REF: ☐☐

Background

1. **The sector in which I am employed is... (Please tick ONE box)**

NHS ☐
Local Authority ☐
Voluntary Sector ☐
Private Sector ☐
Other (please specify) ..... ☐

2. **The title of the organization/service in which I work is**

.....

3. **My job title is**.....

4. **My gender is:** **Female** ☐ **Male** ☐

5. **Which ONE of the following best describes your ethnic origin?**

White ☐
Black - Caribbean ☐
Black - African ☐
Black - Other ☐
Indian ☐
Pakistani ☐
Bangladeshi ☐
Chinese ☐
Any other ethnic group (please describe) ..... ☐

6. **Do you have a disability or chronic health problem? YES** ☐ **NO** ☐

If YES, please specify.....

7. **I have worked in this locality (Maryhill & Woodside) for approximately.....?**

10 or more years ☐
6 to 9 years ☐
3-5 years ☐
1-2 years ☐
Less than a year ☐
Not applicable ☐

8. **I live in the Maryhill or Woodside areas? YES** ☐ **NO** ☐

9. I have had experience of partnership working/collaboration in this locality (other than the Child Health Initiative).....

None ☐
Some (please describe below) ☐

.....

.....

.....

Your involvement with Woodside & Maryhill Child Health Initiative

10. I am a member of..... (Please tick <u>ALL that apply</u>)

Public Health Team ☐
CHI Partnership Steering Group ☐
Positive Parenting Group ☐
NW Children & Young Persons Forum ☐
NW Children & Young Persons Forum Sub Group (Early Years) ☐
Monitoring Group for Family Support Worker post ☐
Other Local Groups (Please specify below) ☐

.....

.....

11. I was a participant in..... (Please tick <u>ALL that apply</u>)

Consultation Seminar 2002 ☐
Information sessions/updates on Family Support Worker ☐
Training event on 'Handling Children's Behaviour' 2004 ☐
Workshop on Storysacks ☐
Training event on 'Baby Massage' ☐
Joint work with an individual family with the FSW ☐
Other group or individual activities (Please specify below) ☐

.....

.....

12. I have made a referral to the Family Support Worker:

YES ☐
NO ☐
NOT APPLICABLE ☐

If YES, please can you describe the type of work and outcome

.....

.....

.....

Your Perceptions of the Child Health Initiative (CHI)

13. How important are the AIMS of the CHI in relation to <u>your own work</u>? Please CIRCLE your answer using a scale of 1 to 5 where 1 is 'Not At All Important' and 5 is 'Very Important'.

	Not at all important ←				→ Very important
"Promote healthy families and healthy communities."	1	2	3	4	5
"Improve local structures for delivery of services."	1	2	3	4	5
"Improve joint working arrangements."	1	2	3	4	5
"Enhance community based services."	1	2	3	4	5

*Any comment on the CHI **AIMS**?*

14. How relevant are the Child Health Initiative THEMES in relation to <u>your own work</u>? Please CIRCLE your answer using a scale of 1 to 5 where 1 is 'Not At All Important' and 5 is 'Very Important'.

	Not at all important ←				→ Very important
Family Support	1	2	3	4	5
Positive Parenting	1	2	3	4	5
Information for parents	1	2	3	4	5
Joint Training	1	2	3	4	5

*Any comment on the CHI work **THEMES**?*

15. **What do you consider to be the value of the CHI to your own work/area of work?**

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16. **Are there any GAPS in the activities of the CHI that you would like it to address in the future?**

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17. **In your view, what are the main STRENGTHS or BENEFITS of this local joint working arrangement for child health?**

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18. **Are there any DRAWBACKS to this local joint working arrangement?**

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19. **In your view should the CHI involve any other groups or individuals that it doesn't do so currently?** (For example, other staff teams, management group, parents/families, other volunteers and community members)

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20. **Which <u>three activities</u> of the CHI do you think are most important? (Please tick 3 boxes only)**

Contribution by CHI to the development of local children & family policy and planning ☐

Promoting wide community participation in planning & developing policies and practices ☐

Coordination & development of local, multi-disciplinary practices & initiatives (e.g. Positive Parenting Group) ☐

Promoting & developing joint training initiatives ☐

Providing family support ☐

The development of accessible information for parents ☐

CHI related Outcomes

21. This question is about the outcomes you perceive as directly related to the work of the CHI even though other initiatives might have played a part.

1. Read each statement below in the middle column.
2. Go to the **BEFORE** column.
3. Circle the number closest to what you perceived the situation to be like before the CHI was set up or just when you became involved (*1 is 'little', 2 is 'some' and 3 is 'lots'*).
4. Then go to **NOW** column on the right of the page.
5. Circle the number closest to what you perceive the situation to be like ***now*** that the CHI has been operating and is directly related to this initiative.

BEFORE CHI little	some	lots		NOW little	some	lots
1	2	3	I regularly **contribute** to local policy and planning groups on children's wellbeing and parenting.	1	2	3
1	2	3	Support to children and families is **well coordinated** across the different agencies in the local area.	1	2	3
1	2	3	I know **which agencies and individuals** are involved locally in the field of child and family wellbeing and family support.	1	2	3
1	2	3	I **understand the roles** of others who work locally in the field of child and family wellbeing and family support.	1	2	3
1	2	3	I regularly **meet**, formally or informally, with other local workers from other agencies with common interests.	1	2	3
1	2	3	There is well-coordinated and accessible **information** for local parents	1	2	3
1	2	3	I have opportunities to participate in **local joint training** events on child and family wellbeing and parenting topics.	1	2	3
1	2	3	I know who and how to make a referral when there is a need for **family support** to help families with homemaking skills, raising awareness of benefits and helping them to access local services and facilities.	1	2	3
1	2	3	There is **quality** support available to individual families on homemaking skills, raising awareness of benefits and helping them to access local services and facilities.	1	2	3

22. Do you have any suggestions how the CHI could develop and improve?

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23. Any other comments about the CHI or this evaluation?

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Many thanks for your contribution!

Please send your completed questionnaire to Julie Ridley in the stamped addressed envelope provided by Monday 31st October 2005

13.5. Appendix 5: Other Comments About CHI or the Evaluation from Survey Respondents

1. Would like more info on training events this could be my fault too, missed meetings or maybe they are for particular group of people.
2. I have been happy to be involved and look forward to more partnership working in the future
3. Very worthwhile venture. Has the ability to impact on those families most in need of direction and guidance through support, example of positive parenting. The family support worker is to be commended.
4. I found it is useful for CHI to set up regular meetings for different agencies to meet
5. Found evaluation exercise useful in reinforcing my knowledge of the CHI and also partnership working and its benefits.
6. CHI has a strong emphasis on parenting support, which is critical to good outcomes for children
7. Since the team has been active in the area this good work has shown positive results
8. This has been a very positive use of local initiative fund which was made available by Scot Exec back in 2002. The Coordinator herself can be largely attributed to its success. Partnership working in this particular area is also regarded as a strength for Maryhill/Woodside.
9. The evaluation has been pretty comprehensive. The achievements of the CHI are not just the result of positive partnership working but also represent the dedication, commitment, drive and skills of the current CHI staff. The CHI has been fortunate in that there has been no change in the staff and the partners on the steering group have also remained consistent.
10. The Coordinator and FSW work very well together. These roles have development the partnership group and work for children and families. The services provided are the partnership group and work for children and families. The services provided are invaluable.

13.6. Appendix 6: Logic model worksheet: Depicting a theory of change

One key value of a logic model is that it displays the chain of connections showing how a program is expected to work to achieve desired results. When you use a table or chart and list items in the input, output, and outcome columns you may lose the opportunity to show connections among and between items. This worksheet uses boxes that you connect by arrows to show the sequence of events. You may call this your *theory of change*, your *program theory* or *theory of action.* When finished, such a logic model will explicitly show the assumed connections linking inputs to outcomes.

This worksheet only provides a start. It is likely that you will have more or less boxes and arrange them differently on your sheet. Put a unique, separate item in each box. Then, show how the boxes relate to each other by drawing connecting lines and arrows. Sometime feedback loops and double directional arrows are necessary. In this way, you can display both the sequence and the interaction of effects.

Remember, the model does not have to be linear or read from left to right. You might draw a vertical logic model that reads from top to bottom or bottom to top. A circle may better express your program or components within a program.
In the early stages of developing a logic model, give yourself plenty of space. Later, you can transfer your work to a one-page, neat copy. It is often helpful to color code chains of connections or specific sections of your logic model.

A logic model conveys the *story* of your program. It does not show all the detail and it is not an exact representation. However, it should depict those aspects that stakeholders feel are important and essential for showing how the effort works. If a logic model becomes too complex, consider creating "nested" models where each separate model captures a different level of detail or scope. There is a space on the worksheet to list assumptions. It may be less complicated to list these on a separate sheet. However, don't forget to carefully think about and list the beliefs and ideas you and others have about how and why you think the program will work. Often, inaccurate or overlooked assumptions are the reason for unsatisfactory results.

Also there is a space on the worksheet for external factors. Again, it may be less complicated to list these on a separate sheet. These are part of the environment in which the program exists that often influence how well the program succeeds and over which we may have little control.

For additional help creating your logic model, go to www.uwex.edu/ces/lmcourse