

**THE IMPORTANCE OF BEING
EFFICACIOUS: ENGLISH HEALTH AND
SOCIAL CARE PARTNERSHIPS AND
SERVICE USER OUTCOMES**

By

HELEN E. DICKINSON

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degree of Doctor of Philosophy**

**School of Social Policy
Health Services Management Centre
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Abstract

The need for health and social care agencies and their professionals to work in partnership is a central component of contemporary English health and social care policy. Partnership is predicated on the notion that this way of working improves services and outcomes for service users. However, as there is little evidence that partnerships improve service user outcomes, some commentators suggest that this indicates either a failure of the policy or a deficit in terms of implementation.

This thesis investigates the link between health and social care partnerships and service user outcomes. Rather than adopting the types of rationalist and instrumental approach which the majority of studies in this field have done, the thesis develops a new conceptual framework for partnership which is interpretive and performative.

This framework is developed and tested in four exploratory case study sites and concludes that partnership is not necessarily simply an instrument of improvement in a traditional sense. The power of partnership lies in its cultural and symbolic value. This takes partnership beyond traditional discussions of partnership and governance; rather than representing a particular mode of governance, instead arguing that partnership is an active tool of governance.

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Glossary

A&E	Accident and Emergency
BtPCT	Beddington Teaching Primary Care Trust
CAF	Common Assessment Framework
CLG	Communities and Local Government
CP	Children's Partnership
CSCI	Commission for Social Care Inspection
DLDS	Drumston Learning Disability Services
EBM	Evidence Based Medicine
GP	General Practitioner
HAZ	Health Action Zone
HR	Human Resources
HSMC	Health Services Management Centre
ICT	Information and Communication Technologies
IOR	Inter-organisational relationships
JCB	Joint Commissioning Board
LAA	Local Area Agreement
LD	Learning Disability
LEH	Lower Easingham Hospital
LSP	Local Strategic Partnership
ND	Newfield
NHS	National Health Service
NPG	New Public Governance
NPM	New Public Management
TCE	Transaction Cost Economics
PA	Public Administration
PAM	Public Administration and Management
PCT	Primary Care Trust
POET	Partnership Outcomes Evaluation Toolkit
RDT	Resource-dependency Theory
RE	Realistic Evaluation
RISS	Rockinborough Integrated Care Service

SHUH South Hemly Hospital

ToC Theories of Change

tPCT Teaching Primary Care Trust

Preface

The research which underpins this thesis has been the core feature of my work over the last five years when I commenced with a studentship funded as part of the department's research programme around health and social care partnerships and, in particular, work which culminated in an international workshop held in May 2006. As a consequence I have taken the opportunity to present and publish parts of the material that constitute this thesis. This short section documents the publications which have been produced to date. Copies of these papers can also be found in Appendix One.

From a workshop held in 2006 a special edition of the journal *Health and Social Care in the Community* was published, where I, along with my two PhD supervisors acted as Editors. This included a guest editorial (Glasby *et al.*, 2006) which sought to map out the contours of the existing health and social care partnership literature and the major areas of debate that exist within this arena. This paper draws on material produced for this thesis which appears in chapters one and four, exploring the issues surrounding health and social care partnerships and their links to service user outcomes.

Within this edition of the journal another paper was also published (Dickinson, 2006) which draws on work set out in chapter four. Based on parts of the review of the methodological literature presented in this chapter, this paper suggests a potentially different methodological framework for the evaluation of health and social care partnerships.

A year later, following the presentation of some of the early research findings at the 2007 Social Services Research Group conference, I was asked to write up a short piece outlining the POET process which was devised as a central part of the research for this thesis. This was published in the journal *Research Planning and Policy* (Dickinson, 2007) and is also set out in chapter four. Similarly, following discussion of one of the case study sites at the 2008 International Journal of Integrated Care conference, I was invited to write up these findings as an article for the *Journal of Integrated Care* (Dickinson *et al.*, 2009a). This article is based on only one of the case study sites, rather than across all four, but the paper draws from what is presented here in chapter five.

Finally, drawing on another of the case study sites investigated within this research an article is in press with *Public Management Review* (Dickinson & Glasby, forthcoming) which uses the evaluation findings at this one site to illustrate a number of the pitfalls which health and social care partnerships encounter in everyday practice. This paper draws on some of the material set out in chapters five and six.

Chapter One: Introduction

“To argue for the importance of partnerships is like arguing for ‘mother love and apple pie’. The notion of partnership working has an inherently positive moral feel about it and it has become almost heretical to question its integrity”
(McLaughlin, 2004: p 103)

1.1 Introduction

“Partnership” appears as a *leitmotif* of New Labour’s approach to public policy. The need for health and social care agencies and their professionals to work together in partnership is a central feature of policy in this field. English central government has repeatedly stated that the driver for partnership is to ensure that recipients of health and social care services receive “joined-up responses” to “joined-up problems”. Although the desire for health and social care agencies to work together is not new, this topic has been a particular focus of successive Labour governments over the last thirteen years and is the core subject addressed in this thesis.

This chapter provides an introduction, laying the foundations for the new perspective of partnership developed as a result of the research conducted for this thesis. This introduction starts by providing definitions of the major concepts and terms which are employed throughout the thesis. Of key consideration is what is meant by the term partnership and how this relates to the concept of governance. Given that partnership is most often predicated on the notion that working in this way should improve

service user outcomes the chapter then moves on to consider the “performance” of partnerships and what the existing evidence says about the impacts of partnership. Following this initial scene setting, the chapter turns to the main line of argument set out in this thesis and provides an overview of the case that will be developed throughout the proceeding chapters. In doing so, this thesis makes two primary contributions to existing knowledge. Firstly, it develops this argument into a new theory of partnership; one that transcends traditional instrumentalist analyses. Secondly, in the course of this research the Partnership Outcomes Evaluation Toolkit (POET) was developed which is an evaluative and developmental tool devised specifically to evaluate health and social care partnerships in terms of service user outcomes. Both of these additions add significantly to the existing evidence base and advance the types of theoretical and conceptual models that have traditionally been used to study the concept of partnership in health and social care.

1.2 Partnership and governance

Powell (e.g. 1999; 2000) argues that reform of the welfare state featured highly in the manifesto of the New Labour government elected in 1997. ‘New Labour seeks to move from a passive to an active, preventative welfare state. For example, while the traditional NHS was largely concerned with ‘repair’, the ‘new NHS’ will be more active in preventing illness, ensuring people do not fall ill in the first place’ (Powell, 2000: p. 43). Partnership was one of the primary means through which this government proposed to reform the welfare state. Just over a year after they took office, the discussion document *Partnership in Action* (Department of Health, 1998b)

was published and this clearly set out the government's intention to drive the improvement of health and social care services through partnership:

'The Government aims to build a modern, dependable health service with patients having fast access to high quality services based on need...Instead of the fragmentation and bureaucracy of the internal market, we are building a system of integrated care, based on partnership...We are putting more money than ever into both the NHS and social services. Money tied to modernisation and better services for people...We want to see health and social services working much more closely together to protect those in need...This document sets out our plans to make partnership a reality throughout England by removing barrier in the existing system, introducing new incentives for joint working and achieving better monitoring of progress towards joint objectives. The result will be a system where the energies of health and social services are not dissipated in fruitless debate on boundaries'
(Department of Health, 1998b: p. 3).

The discussion set out in this document acknowledges that there is 'no single, simple solution' (p. 6) and goes on to suggest that joint working is needed at three levels (strategic planning, service commissioning and service provision). Reform of the welfare state was viewed as a complex process, but partnership would be a central means of achieving this and should ultimately lead to improved outcomes for service users and their carers: 'the key objective is that the user receives a coherent integrated package of care and that they and their families do not face the anxiety of having to

navigate a labyrinthine bureaucracy' (p. 6). In the course of setting out its case for reform and the mechanisms that would achieve this, the document refers to the need for joint working, cross-sectoral working, integration and collaboration. Yet, despite being employed as seemingly distinct terms, all of these concepts are subsumed under the umbrella of partnership. However, this is not the only document to define partnership in such a broad sense. The Audit Commission (2005: p. 4) defines partnership as 'an agreement between two or more independent bodies to work collectively to achieve an objective' and similar definitions have been offered by academics such as Armistead and Pettigrew (2004), Edwards (2007) and Huxham and Vangen (2005) amongst others. Thus, partnership appears in academic and policy literatures as something of an all encompassing concept for a variety of different ways of organising.

The desire for health and social care agencies to work together was not necessarily new in 1997 (as chapter two illustrates), but this agenda was pursued with renewed vigour following the election of the New Labour government. *Partnership in Action* set the scene for what was to come with a range of governmental documents, policies, legal acts and court rulings which all sought to compel health and social care agencies to work together for the good of service users, their carers and in some cases the wider population (e.g. Secretary of State for Health, 1997; Department of Health, 1998a; Health Act, 1999; Secretary of State for Health, 1999; Coughlan Ruling, 1999; Secretary of State for Health, 2000a; 2000b; Health and Social Care Act, 2001; Secretary of State for Health, 2001b; Department of Health, 2001; 2002; HM Treasury, 2003; Children Act, 2004; Department of Health, 2005a; 2005b; 2005c; 2005d; Secretary of State for Health, 2006; Secretary of State for Communities and

Local Government, 2006; Local Government and Public Involvement in Health Act; Secretary of State for Health, 2008; 2009). Successive Labour administrations were clear that partnership was a key component of reforming English health and social care and therefore crucial in terms of the governance of the welfare state. As Sullivan and Skelcher (2002: p. 1) describe, 'partnership is the new language of public governance'.

Having demonstrated the centrality of the concept of partnership to New Labour and the modernisation of health and social care, the chapter now moves on to consider the concept of governance in more detail as this is a second key idea in this thesis. As the definitions derived from the academic and policy literatures illustrate, partnership is not a coherent concept and encompasses a range of terms. Governance is a notion that has been widely invoked to make sense of the different patterns in which organisations interact with one another and therefore offers some helpful insights into this area. Governance is broadly concerned with the sorts of institutions and modes of authority which are used to coordinate or control activities within a specific area. Kooiman (1993) describes governance as the means of steering a community, which has resonance with Mayntz's (1993: p. 11) definition as a 'mode of social co-ordination or order'.

Klijn (2008) illustrates that there has been substantial interest in the field of governance over the past thirty years as many parts of the world have experienced changes in the structures and practices of commercial, public and third sector organisations. Rhodes (2000: p. 6) argues that governance 'has now become the defining narrative of British government at the start of the new century, challenging

the commonplace notion of Britain as a unitary state with a strong executive'. Yet as Newman (2001: p. 12) highlights, 'governance has become a rather promiscuous concept, linked to a range of theoretical perspectives and policy approaches'. Governance acts as a 'descriptive and normative term, referring to the way in which organisations and institutions are (or should be) governed' (p. 16). This is a crucial observation given there is a normative preference for network-based collaborative forms of governance present in much recent policy literature.

The case for networks is often made as a reaction to the tensions that arise from hierarchy and market modes of governance. Williamson (1975) provided one of the first attempts to differentiate between different modes of governance writing from a perspective of *Transaction Cost Economics* (TCE). TCE suggests that where individuals or organisations have partially overlapping goals they are forced to cooperate. The process of collaboration will only occur therefore, if it is in the mutual interest of each party to try control or influence the other's activities. Cooperation requires interdependence which calls for some form of transaction or exchange, where each individual gives something of value (e.g. labour) and receives something of value in return (e.g. money). This form of interdependence is known as a *market* relationship, where the transaction between two parties is mediated by a price mechanism. In a competitive market this price mechanism should assure both parties that the exchange is equitable and this demand for equity attracts transaction costs. Due to their relatively high transaction costs, markets tend to encourage organisations to be fairly independent and only collaborate when necessary.

However, Williamson (1975) observed that markets are not always an efficient use of resources. If it is difficult to establish the exact price of a good, or the transaction costs become too high, a *hierarchy* may be more efficient in mediating economic transactions between its members at a lower cost. In a hierarchy, each party contributes labour to the corporate body which places a value on this and compensates it fairly. As the corporate body is trusted to mediate this relationship transaction costs are lower overcoming some of the difficulties markets have with collaboration. Nonetheless, due to their formalisation and routine lower transaction costs tend to come at the price of flexibility.

The forms of market and hierarchy received much attention from organisational theorists and economists (for example Weber, 1968; Arrow, 1974) however, work by sociologists and anthropologists (for example Dore, 1973; Durkheim, 1933) suggested that these ideal types were insufficient in describing and explaining all contexts. These theorists recognised the power of cultural forces and observed that certain contexts encouraged the socialisation of individuals into systems and under these circumstances individuals acted not according to the forces of price or the types of power associated with hierarchical relationships, but rather due to socio-cultural forces (institutions). These forms were therefore extended. although this third mode is often referred to by different names: Ouchi (1991) speaks of markets, bureaucracies and clans; Bradach and Eccles (1991) of price, authority and trust; Mayntz (1993) of markets, politics and solidarity. However, this tripartite is most frequently represented as markets, hierarchies and *networks* (e.g. Thompson *et al.*, 1991; Lowndes & Skelcher, 1998; Rodríguez *et al.*, 2007).

This third mode is characterised by actors recognising complementary interests and developing interdependent relationships based on trust, loyalty and reciprocity to enable and maintain collaborative activity. It is proposed that within networks, actors are working towards the same aims and objectives and therefore generate trust between them. This trust reduces transaction costs and without creating the same formal structures associated with hierarchies (although actors will likely be bound by shared understandings or informal rules). The trust mechanism means that partners are able to work together more effectively as they perceive less uncertainty between stakeholders and are better able to predict the actions of their partners (Putnam, 2003; Rowlinson, 1997). Trust is essentially a mechanism for managing risk. Table 1.1 illustrates these three modes of governance along with the characteristics which tend to be associated with each. As this table illustrates, many of the terms associated with hierarchy and markets seem rather negative when viewed against those of networks which are often seen as “relational”, based on “reciprocity” and effectively playing to “complementary strengths” as opposed to being based on “contracts” or “employment relationships”. This thesis draws heavily on the work of cultural theorists as the early work on networks did. Early anthropologists and sociologists argued that rules and values were crucial in terms of driving networks and this is a theme also developed within this thesis, although in a rather different sense.

Table 1.1: Modes of governance and characteristics

	Market	Hierarchy	Network
<i>Normative basis</i>	Contract	Employment relationship	Complementary strengths
<i>Means of communication</i>	Prices	Routines	Relational
<i>Methods of conflict resolution</i>	Haggling – resort to courts	Administrative fiat – supervision	Norm of reciprocity – reputational concerns
<i>Degree of flexibility</i>	High	Low	Medium
<i>Amount of commitment among the parties</i>	Low	Medium	High
<i>Tone or climate</i>	Precision and/or suspicion	Formal, bureaucratic	Open-ended, mutual benefits
<i>Actor preferences or choices</i>	Independent	Dependent	Interdependent

Source (Lowndes & Skelcher, 1998: p319)

In applying the three ideal modes of governance to an English health and social care policy context, Glasby and Dickinson (2008) suggest it is often characterised as: 1940s-1970s hierarchy; 1980s markets; and, post-1997, networks. English welfare services began life in the voluntary and community sector with various philanthropists and charities gradually developing new ways of responding to the social problems created by rapid industrialisation and urbanisation. It was often the voluntary sector that pioneered developments such as old age pensions, child health services, adult education, affordable housing, and practical support for older and disabled people – many of which became part of a state-led and publicly-funded welfare system following the reforms of the 1940s. The formation of the welfare state represented an era of *hierarchy*. Large government departments were responsible for a series of (often quite separate) welfare services, each with their own regional and local delivery

structures. Authority in such a system was largely top-down, with staff at ground-level reporting up to a lead officer, who would report upwards.

From the late 1970s, a series of national and international economic crises prompted the Conservative governments of Margaret Thatcher (1979-1990) to initiate a process of *market-based* reform. According to the ideology of these reforms, a very large public sector had become massively inefficient; consuming too much of the nation's resources, and serving the interests of staff and welfare professionals rather than people receiving services. In response, the Conservative government purported to reform public services according to market principles, with the public sector increasingly focused on purchasing services from a growing range of public, private and voluntary organisations, rather than providing them all "in-house".

More recently interest has grown in the concept of *networks*, which is often seen as a response to the implications of the changes of the 1980s and the 1990s. The implication of market reforms was that public services had supposedly become increasingly fragmented, with a growing split between commissioners of services and providers from the public, private and voluntary sectors. This is described by Sullivan and Skelcher (2002: pp. 15-20) in terms of 'the hollowed out state', where government continued to be responsible for identifying what services were needed, but much less involved in actually delivering this. It was identified by the New Labour government that at the very time policy was starting to focus on more complex, cross-cutting social problems, the mechanisms for responding to this need were increasingly diverse and fragmented. Against this background, the solution proposed was the notion of "joined-up solutions to joined-up problems", with a much

greater emphasis on inter-agency working and partnership as a means of co-ordinating something of a patchwork quilt of services.

That there has been a linear process of change from hierarchy through markets to networks over time is a compelling argument and useful shorthand. Yet, this perspective is an over-simplification in the sense that these types of discussions of governance tend to suggest that markets, hierarchies and networks are mutually distinct forms of organising which are identifiably different from one another. Indeed, this is the position held by a number of prominent theorists (for example, Powell, 1990). However, as several empirical research projects have demonstrated, networks actually take a number of different forms; some of which are ‘hierarchical networks’ (e.g. Hennart, 1993) and others ‘market networks’ (e.g. Macneil, 1980; Williamson, 1985). The concept of the quasi-market denotes the presence of some broadly market-based relationships but within a predominantly hierarchical setting (Le Grand & Bartlett, 1993). As this thesis illustrates, the term partnership has been used in English health and social care to describe hierarchical and market-based relationships as well as more network-like types of arrangements.

These modes of governance have been incorporated into Osborne’s (2006) overview of the broader sphere of Public Administration and Management (PAM). Osborne charts a three-stage model from Public Administration (PA), through New Public Management (NPM) to what he terms New Public Governance (NPG). This analysis is set out in Table 1.2 and illustrates the development of this broad area of research and the various theories and frameworks that are valued in association with these different stages. Within the governance literature NPG has in recent years been seen

as the end point which governments should be striving for; basing their modes of governance on trust and relational contracting in order that they overcome the hierarchical and market based systems of old.

In some parts of the literature there is a tendency to equate health and social care partnerships with networks (see Hudson, 2004a) and take this as an illustration of the English welfare system developing towards NPG. Given the prominence of NPG and the tensions and difficulties inherent in hierarchy and market modes of governance, networks appear inherently 'desirable in that they are more flexible and responsive than hierarchies, and capable of avoiding the 'anarchic' disbenefits of markets' (Newman, 2001: p. 17). The need for a network form of governance is often predicated on the basis that systems are overly bureaucratic or seen as having high transaction costs. Yet, in practice, most governments would likely be terrified at the idea of creating or inheriting a system which is governed purely by trust or relational contracts and offer little in the way of accountability as traditionally understood in English public services.

Table 1.2 Elements of the NPG, in contrast to PA and the NPM

<i>Paradigm/key elements</i>	<i>Theoretical roots</i>	<i>Nature of the state</i>	<i>Focus</i>	<i>Emphasis</i>	<i>Relationship to external (non-public) organizational partners</i>	<i>Governance mechanism</i>	<i>Value base</i>
<i>Public Administration</i>	Political science and public policy	Unitary	The policy system	Policy implementation	Potential elements of the policy system	Hierarchy	Public sector ethos
<i>New Public Management</i>	Rational / public choice theory and management studies	Disaggregated	Intra-organizational management	Service inputs and outputs	Independent contractors within a competitive market-place	The market and classical or neo-classical contracts	Efficacy of competition and the market-place
<i>New Public Governance</i>	Organizational sociology and network theory	Plural and pluralist	Inter-organizational governance	Service processes and outcomes	Preferred suppliers, and often inter-dependent agents within ongoing relationships	Trust or relational contracts	Neo-corporatist

(Source: Osborne, 2006: p. 383)

Just as Glasby and Dickinson (2008) argue that a linear transition from hierarchy through markets to networks is an over-simplification, Osborne also notes that a linear transition from PA to NPG, ‘inevitably...is a simplification – elements of each stage can often coexist with each other or overlap’ (p. 378). In other words, the development of PA through NPM to NPG does not mean that all PAM is now NPG, or that elements of PA or NPM no longer exist. Osborne suggests that all three exist and overlap in the complex patchwork of this sphere. In practice, hierarchical forms have tended to dominate English public services (as they have in most other developed countries). McGuire (2006) notes: ‘[I]t is important to recognise that bureaucracy is not going away; collaboration still complements, rather than supplants, single organisation and management’ (p. 40). Even where markets and networks have become more prominent in recent years, they are typically new ways of handling relationships between hierarchies.

1.3 Health and social care partnerships and performance

This section investigates the link between partnership and performance in order to assess the types of impacts that partnership working has had in practice. Despite the fact that partnership working is most frequently predicated on the idea that it should improve service user outcomes, several commentators have noted that there is little empirical evidence to clearly demonstrate such a link (e.g. Dowling *et al.*, 2004; Glasby & Lester, 2004; Leathard, 2005; Dickinson, 2008). However, from their review of the literature, Dowling *et al* (2004) observe that most research into partnerships tends to focus on process (how agencies work together), rather than

outcomes (what impact this has on service users). This is an interesting observation and one that others have made elsewhere (e.g. Dickinson, 2008). This section investigates three possible reasons for trend: the difficulties involved in evaluating the outcomes of partnerships; the failure to identify what outcomes partnerships should achieve; and, an assumption that partnership is a public good.

Various researchers have noted at length the difficulties involved in making a link between partnerships and service user outcomes (e.g. Glendinning *et al.*, 2005) and suggest that a lack of evidence of this link might relate to the fact that partnerships are difficult to research. Indeed, the complexities of researching partnerships are well-established (see Dickinson, 2008 for a detailed overview). Yet, many of the difficulties that are associated with evaluating partnerships are equally applicable to other types of complex policy initiatives. Therefore these difficulties might not be insurmountable. The reason for interest in processes over outcomes may run beyond the technicalities of designing appropriate research frames to a much wider issue of what it is that partnerships are fundamentally supposed to achieve.

In their analysis, Dowling and colleagues (2004) observe that:

'[O]utcome measures tend to be as widely applicable to other modes of coordination as to partnerships. Improving the accessibility, efficiency, effectiveness and quality of services, and making their distribution more equitable, are not exclusive to partnerships or dependent on partnerships for their accomplishment (although it might be argued that partnerships are more likely to realise them). After, all, much social policy during the 1980s and 1990s in the UK sought to achieve precisely these objectives by introducing markets into both health and social care. Equally, enhanced experiences for

staff, users and carers are outcomes sought in many social welfare systems, whether these utilise partnerships or not' (p. 314).

Dowling *et al* are expressing a fundamental concern that it is not clear precisely what ends partnership should achieve and how this differs from other modes of improvement. A concern with which outcomes - or which aspects of performance to consider when researching partnerships - is also a concern of the wider inter-organisational relations (IOR) literature :

'Performance is something of the Holy Grail of IOR research. Most efforts to evaluate IORs either explicitly or implicitly discuss some aspect of organisational performance. While performance can be measured, there are two basic problems. First, which measures of performance should be considered? Second, to what extent is an organisation's performance attributable to its involvement with other organisations? (Provan & Sydow, 2008: p. 702)

Provan and Sydow argue that it is unclear in the IOR literature what kinds of performances should be measured and then there are further technicalities with assessing the contribution that each partner makes to that outcome. There are echoes of this in the argument Schmitt (2001) constructs, suggesting what is often missing from evaluations of collaborative efforts is an explanation of *why* certain outcome indicators were selected. Schmitt laments the absence of a rationale linking what it is that partnership should achieve and the selection of outcome indicators to measure this by believing it is often unclear why collaborative efforts are held to account against particular outcomes or why some measures are valued over others.

What is implicit in the arguments of Dowling and colleagues and that of Provan and Sydow is a sense that partnerships are a clear means for bringing about specified ends. In making the case about why health and social care partnerships should work in partnership, the majority of central government documents tend to make fairly vague and abstract allusions to the idea that this will be broadly better for service users and carers, but with little more specificity than this. This is despite the fact that in 2005 the social care Green Paper *Independence, well-being and choice* (Department of Health, 2005d) stated that in order ‘to turn the vision for social care into a reality’, ‘clear outcomes for social care’ were needed, ‘against which the experience of individuals can be measured and tested’ (p. 25-26). This document went on to develop the outcomes set out in *Every Child Matters* (HM Treasury, 2003) for adult social care services. These outcomes were then given further emphasis in the following year when they were included in the joint health and social care White Paper *Our Health, Our Care, Our Say* (Secretary of State for Health, 2006). The outcomes set out in these documents are illustrated in Box 1.1 and arguably represent the main attempt within policy to articulate the outcomes that health and social care agencies should be aiming to achieve together.

Box 1.1: Children and adult service outcomes in policy

Children's services outcomes	Adult service outcomes
<ul style="list-style-type: none">• Being healthy• Staying safe• Enjoying and achieving• Making a positive contribution• Economic well-being	<ul style="list-style-type: none">• Improved health• Improved quality of life• Making a positive contribution• Exercise of choice and control• Freedom from discrimination or harassment• Economic well-being• Personal dignity

One thing that is incredibly striking about these outcomes is their aspirational nature. These are large and encompassing measures. Beyond simply the technical difficulties in measuring these and making attributions to public sector actions, if services were really held to account against these measures they would inevitably fail. How could the interventions of health and social care services really secure the improved health of the entire population, let alone the economic well-being, personal dignity and freedom from discrimination? However, they do possess a degree of power in their vagueness and abstraction. The same set of outcomes can be made applicable to a whole range of different types of services, despite the fact that they may not be interpreted in quite the same way by all stakeholders. In this sense they could be considered well suited outcomes for partnership working. They provide an overarching vision which multiple partners can sign up to, without actually meaning very much at the same time. Given their lack of further explanation and exploration it

is unclear what their ultimate purpose is beyond offering some rather vague and abstract vision for services.

It would be very difficult to argue against the outcomes set out in Box 1.1. Not many people would probably welcome poorer health and a poorer quality of life, for example. Yet, not many people could probably tell you what improved health and improved quality of life looks like definitively, or how that might compare to the concepts held by another individual. The value of these outcomes may then not be as clear ends that public services might be held to account against. Indeed, these outcomes are so complex and multi-faceted that it would be difficult to argue that public services alone had been responsible for changes in these. What these outcomes do provide is a common vision which is attractive to a range of different stakeholders, and which goes beyond the types of technical performance management indicators which governments are often criticised for (e.g. waiting lists, accident and emergency waiting limits). This therefore raises issues about the nature of “performance”. Although the notion of performance is often treated relatively simplistically in the literature, McKenzie (2001) argues that it is a much more complex concept in practice:

‘Performative objects are unstable rather than fixed, simulated rather than real. They do not occupy a single, “proper” place in knowledge; there is no such thing as the thing-in-itself. Instead, objects are produced and maintained through a variety of sociotechnical systems, overcoded by many discourses, and situated in numerous sites of practice’ (McKenzie, 2001: 18).

Performance is not a simple, coherent and stable concept; rather, it is dynamic and shifts in relation to dominant socio-cultural and discursive forces. Therefore, what is

considered “high” performance will alter according to the values and norms associated with the cultures and institutions of systems.

McKenzie (2001) goes on to suggest that there are three dominant types of performance: organisational (efficiency); technological (effectiveness); and cultural (efficacy). Efficiency is considered as a means to utilise the minimum inputs possible to obtain a required quantity and quality of outputs. Efficiency therefore might be represented as “*doing the thing right*”. Effectiveness refers to the extent to which an organisation has a programme of activities that will deliver its established goals or intended aims; effectiveness, therefore, is about “*doing the right thing*” to deliver the outcomes it has determined (or has been set). Efficacy on the other hand relates to the extent to which an organisation is perceived to be achieving outcomes that are valued by its main stakeholders. Efficacy, then, is about “*according with conceptions of rightness*” in the eyes of service users, their carers, members of the public and their democratic representatives. Efficacy therefore clearly incorporates consideration of the types of institutions which are influential in terms of particular stakeholder groups and settings.

Much of the literature pertaining to organisational performance gives more emphasis to effectiveness and efficiency than efficacy. Arguably this is in-line with the dominant techno-bureaucratic discourses which tend to be associated with the English public sector (Harrison *et al.*, 2002) and which also run through the larger commercial sector high performance literatures (e.g. Peters & Waterman, 1982; Kotter & Heskett, 1992; Jain, 1998; Foster & Kaplan, 2001). Dominant concepts of *what* organisational performance is and *how* this is measured tend to relate more closely to concepts of

efficiency and effectiveness than efficacy. Such concepts align closely with technocratic, rationalist models of performance without explicitly considering the types of cultural forces which Dickinson *et al* (2009b) argue are crucial in effectively influencing and constructing the types of outcomes and measures which organisations and policies are to be assessed by.

Returning again to the theme of partnership and why there has tended to be a focus on process over outcomes within the existing research, beyond explanations that partnerships are difficult to evaluate in terms of outcomes, or that the outcomes which partnerships should achieve have not been clearly articulated, there is potentially a more fundamental explanation for this trend. Such a focus on process is perhaps a reflection of the depth with which the assumption that partnerships lead to better outcomes is so engrained within the public sector (and researchers' beliefs). In other words, if the efficacy of partnership is such that it is fundamentally assumed to be a public good, then it is much cheaper, easier and takes considerably less time to undertake a process evaluation and use this as a proxy indicator of effectiveness.

Given the proliferation of process-based research there is an extensive literature which sets out the main features necessary for the processes of partnership working to be "effective", but without ever defining what an effective partnership actually is (see for example, Wildridge *et al.*, 2004). Yet, this is hardly a new observation, with Yuchtman and Seashore commenting in 1967 on the nature of network performance that 'little attention...has been given to the concept of effectiveness itself. The later remains conceptually a vague construct' (Yuchtman & Seashore, 1967: p. 891). The more descriptive contributions to the literature often set out what they consider to be

“effective” processes and then prescribe these, stating that these factors must be implemented in *all* partnerships that seek to be effective (e.g. Stein & Rieder, 2009). In being prescriptive it appears that there is a correct or ideal way to “do partnership”, yet without ever being clear about for what ends. Partnership is essentially assumed to be a positive mechanism for the wider good without ever really being clear about what this might entail.

An example of the assumed good of partnerships may be found in Rummery’s (2002) critique of partnership “health assessment” tools such as the *Partnership Assessment Tool* (Hardy *et al.*, 2003) and the *Working Partnership* (Markwell *et al.*, 2003). These tools are generally seen as cheap, relatively quick and cost-effective means through which a snapshot of the processes of partnership working might be viewed. Rummery is not the first to criticise these types of approaches. Asthana *et al* (2002) stress concern that they do not provide a comprehensive framework and explicitly distinguishing between inputs, processes and outcomes. Rummery (2002) goes further than this and states that these types of tools sidestep the issue of what partnerships might ultimately reasonably be expected to achieve: improved outcomes for welfare users. In this argument, she is warning against assuming that partnerships *do* lead to better outcomes for service users, but simultaneously asserting that partnerships *should* be about achieving better outcomes for welfare users. Whilst helpful in the sense that she points out the untested assumption about partnerships and their positive impact on service user outcomes that is implicit in these types of tools, Rummery is reproducing the assumption that what health and social care partnerships are ultimately aiming to do is improve service user outcomes.

This thesis argues that partnership is not a means-end mechanism as it has traditionally been treated. Partnership is not a coherent concept that is introduced to bring about particular changes in service user outcomes but instead is an active form of governance. The role of cultural performance in shaping the values and concepts which various actors hold in relation to the notion of governance in health and social care has been much overlooked. This thesis seeks to explore this phenomenon in relation to health and social care partnerships. Before going on to set this line of argument out in more detail, the remainder of this section summarises the existing evidence about the impacts of partnership working in relation to McKenzie's three types of performance. The extant evidence, as a number of commentators have indicated, is far from definitive. However, what this overview does clearly demonstrate is that the impacts of partnership are more pronounced in relation to the notion of efficacy, than efficiency or effectiveness.

1.3.1 Efficiency

Despite the fact that Leutz (1999) notes that 'integration costs before it pays', there is some relatively strong evidence from international programmes that efficiency savings can be an impact of collaborative working. PRISMA (Hébert, 2003) and PRISMA France (see Jöel & Dickinson, 2009 for detail) demonstrate an improvement in various indicators (including autonomy) and reduced hospitalisation rates for the same costs. This was also noted in the English experiment established in Darlington and evaluated by Challis *et al* (1988) and recent evaluation of the Partnerships for Older People's Projects (POPPS) which suggest that integrated early intervention programmes can generate resource savings of between £1.20 and £2.65 for every £1

spent (PSSRU, 2010). It would appear that where there is an incentive for health and social care teams to promote downward substitution (i.e. using community services more intensively instead of more costly acute services) then efficiency savings may be realised. However, from a review of the international literature, Johri *et al* (2003) highlight an important caveat to this observation: such an incentive typically only works where teams are allowed to keep any efficiency saving that they make.

From a recent review of the existing literature concerning the efficiency of integrated care, Turning Point (2010: p. iii) conclude that:

‘Meeting people’s needs with a preventative and integrated approach to health and social care can create efficiencies and savings. However, future studies do need to consider the long term financial benefits. Many of the studies that concluded that integrated care was not cost effective were conducted over short time periods, and many of the benefits will accrue as individuals remain independent well into the future. In particular, those integrated services that have a focus on early intervention are designed to prevent needs escalating in years to come, and therefore, the real benefits will be realised over time’.

The report that this quote comes from states that its purpose is ‘to contribute to the development of a strong evidence base to support the development of integrated care’ (Turning Point, 2010: p. 1). Besides finding some evidence to support this position, the report concedes that it is relatively weak due to evaluative difficulties, but that this should develop over time. Many of these difficulties are associated with attempting to measure efficiency impacts within whole systems. Whilst it is relatively

straightforward to calculate efficiency savings within a single tightly-bounded partnership (such as PRISMA or the Darlington experiment), once this is considered within the context of multiple partnerships then it becomes more difficult to make these kinds of judgements. Changes in one type of linkage might have inevitable knock-on effects for other parts of the system.

We are yet to see results of programmes such as the Operational Efficiency Programme which is being conducted by HM Treasury. Total Place pilots are mapping the flow of money within public services within particular locales with the intent of making efficiencies through public service organisations working together differently (sharing back office functions etc). Early evidence from the 13 pilot sites suggests that considerable efficiencies might be made through these means (Brindle, 2009). Yet these do not consider a range of other potential partnerships, for example between individuals or populations and the state, or between commercial sector organisations and the state. Moreover, there might be questions about the sustainability of efficiency savings such as these. Thus, from a review of the international literature of health and social care collaboration, Joël and Dickinson (2009) conclude:

‘Although the network is often presented as a form of ideal of economic perfection, this assumption is not necessarily borne out through the empirical literature. At the moment, there are a large range of networks whose economic impact are difficult to evaluate due to insufficient data and because network targets are not sufficiently obvious. As a result, it remains difficult for governments to change the nature of their healthcare systems, to generalise successful experiences from individual integrated healthcare networks and to encourage medical teams to change their practice. Hardly surprisingly,

therefore, many networks remain small and time-limited, and it remains difficult to produce a definitive set of economic indicators which may facilitate quick and effective evaluation. To achieve this, networks will need to be seen not in isolation, but as part of wider social and political systems' (p. 117).

Considering the efficiency of whole systems means that questions are inevitably asked about measures of need. From a series of Australian studies, Esterman and Ben-Tovim (2002) concluded that a lack of coordination may hide a lack of resources. What this implies is that more effective partnership working might actually reveal needs that are not met. If public services have a responsibility to meet these needs this will increase costs at least in the short term. In the long term this might increase the prevalence of upstream interventions and reduce overall costs, but as the Turning Point (2010) review indicates, at present we do not have the evidence to make these judgements. Given the range of different ways that the term partnership has been employed there is not a clear set of evidence that points to this as being a more efficient means of delivering public services.

1.3.2 Effectiveness

Thomas and Palfrey (1996) define effectiveness as the extent to which partnerships have achieved either their own stated objectives or those set externally, for example by central government, Department of Health, Strategic Health Authorities, the Care Quality Commission or local politicians. Given that it has already been noted that it has not always been clear precisely what outcomes (measures of effectiveness) partnerships are charged with delivering at a national level this might not be as straightforward a task as initially appears. This section investigates the more popular

measures of effectiveness which have been employed to evaluate health and social care partnerships.

The On Lok project in the USA (see Eng *et al.*, 1997 for overview) found significant improvement in a variety of functional indicators for individuals and this is attributed to the integrated care programme. However, Yordi and Waldman (1995) suggest that this programme helped individuals develop compensatory skills to adjust and cope with their impairments, rather than being able to reverse these conditions. The Canadian PRISMA programme (see Hébert *et al.*, 2005 for overview) found some evidence of maintenance of service users' functional autonomy, although this dropped off significantly in the third year of the project thus questioning the sustainability of these impacts (Tourigny *et al.*, 2004). Similarly, the Vittorio Veneto and Rovereto projects in Italy demonstrated improvements on several functional measures for individuals receiving integrated care compared with control groups (Landi *et al.*, 1999; Bernabei *et al.*, 1998). There are also several examples of research into health and social care collaboration which find that this has no statistically significant impact on clinical indicators or positive impact on functional levels of service users (e.g. Brown *et al.*, 2003; Davey *et al.*, 2005; Hultberg *et al.*, 2002; 2005). Overall then, there is some evidence of impact on clinical and functional impacts, although this is limited and there are questions about the research underpinning some of these findings and the sustainability of these impacts.

Independent living is an outcome indicator which been used particularly in the evaluation of older people's services. The rationale underpinning this is that if health and social care organisations work in partnership, individuals within chronic needs

can be supported to remain in their own homes for longer. Therefore, a measure of effectiveness is the numbers of individuals who remain in their own homes (and there are also links to efficiency here given that institutional care tends to cost more than community based care). Although the On Lok, Vittorio Veneto and Rovereto evaluations all found that integrated working reduced the cumulative numbers of days older people spent in institutional care, the US Social HMO demonstration projects (see Robinson & Steiner, 1998 for overview) were associated with increased hospitalisation (although there has been widespread debate about the design of this evaluation - see Kane *et al.*, 1997; Leutz *et al.*, 1995 for further). Boose (1993) suggests that this trend might be explained by better detection rates and follow-up in some of the sites, rather than an ineffective project and illustrates additional contextual factors which had implications for the actions of the team.

In England, a non-randomised comparative study of an integrated health and social care team found a slight tendency for older people to move in to residential care compared to the control group (Brown *et al.*, 2003). This might be suggested to be a sign of failure, given that the intention of this team was to support older people in the community. However, the study also detected higher rates of depression amongst the older people than was predicted at the outset. Ray Jones (2004) – then Director of Adult and Community Services in this area - suggests that this higher usage of residential care is actually a result of agencies working together more closely and sharing more information, thereby lowering the management of risk thresholds for groups with more severe needs than originally predicted. Thus, evidence for impact on independent living is not clear-cut by any means and may be interpreted in different ways depending on the value set or ultimate aims of the audience.

Given the trends noted above it might follow that we would expect service user satisfaction to rise as a result of health and social care partnership working. Evaluations of the US PACE project conclude it is able to offer highly personalised care, effective clinical coordination and continuity, decreases in hospital and institutional admissions and cumulative days used and a positive impact on Medicare costs (Kane *et al.*, 1992; Dooley & Zimmerman, 2003). Yet, despite these observations, Kodner and Kay Kyriacou (2000) note that PACE is not suitable for all. Individuals enrolled in this programme give up their personal physician - which some were not happy with - and the care programme is delivered within a day-care setting, which was also not appropriate for all. This warns against presuming that service user groups are homogenous and illustrates the value judgements inherent in measures of effectiveness. In their study of an integrated older persons team in England, Brown *et al* (2003) found partnership working did make it easier for individuals to self-refer to the service and more need was identified by the team. The research further concluded that partnership working resulted in the response between referral and assessment being slightly faster (although this was only marginally statistically significant).

In summary then, the evidence about the effectiveness of partnership working is hardly compelling. Moreover, in most of the discussions set out above there are suggestions of methodological difficulties and the presence of value judgements inherent in the application of these measures. Other evaluations of large-scale programmes that have been commissioned by central government to assess various partnership initiatives such as; Sure Start (e.g. National Sure Start Evaluation, 2005), Health Action Zones (e.g. Barnes *et al.*, 2005), Children's Fund (e.g. Edwards *et al.*,

2006), Children's Trusts (e.g. University of East Anglia, 2007), Health Act flexibilities (e.g. Glendinning *et al.*, 2002a), Intermediate care (e.g. Barton *et al.*, 2006), Local Area Agreements (e.g. Office of the Deputy Prime Minister, 2005; 2007) and Local Strategic Partnerships (e.g. ODPM, 2005) have, on the whole, also generally remained relatively inconclusive.

Little consistent empirical evidence has been produced which clearly demonstrates that health and social care partnerships improve outcomes for service users (although the most recent reports from the long-term Sure Start evaluation starts to make positive assessments of this impact, see Melhuish *et al.*, 2008 for example). This is not the kind of rigorous, "scientific" data that evidence-based policy and practice is supposedly based upon. Furthermore, this demonstrates that evidence may potentially be interpreted in any number ways depending on the aims and purposes of the use of this evidence.

1.3.3 Efficacy

In referring to cultural performance, McKenzie is drawing attention to the 'living, embodied expression of cultural traditions and transformations' (p. 8). Drawing on works of critical theorists such as Jean-François Lyotard (e.g. 1984) and Judith Butler (e.g. 1993), McKenzie maintains that notions of knowledge and power are not free from the dominant values of the societies within which they have been forged. McKenzie cites Schechner's (2003) concept of "restored behaviour" as being important in thinking about cultural performance. In line with many sociologists over the past fifty years, Schechner is arguing that our daily lives are filled with habits,

routines and rituals that have become so established over time that we repeat them almost without acknowledging that there may be alternatives. In turn, they are largely shaped – or, as Goffman would argue, constrained - by our interpretation of current social norms which, of course, change over time. Performance is the ‘embodied enactment of cultural forces’ (McKenzie, 2001: p. 8).

This type of performance is clearly quite different to those of efficiency and effectiveness. McKenzie (2001) argues that from the Second World War the western world became increasingly concerned with measuring the performance of individuals, organisations and institutions. This type of performance measurement was, however, firmly entrenched in technico-beaureaucratic notions of performance. What McKenzie illustrates is that this is itself a type of performance. By only being concerned with efficiency and effectiveness and understanding performance according to these terms this sends out strong messages about what is valued within these societies. ‘At each period in each culture one or the other is dominant – one is ascending while the other is descending. Naturally, these changes are part of changes in overall social structure; yet performance is not a passive mirror of these social changes but a part of the complicated feedback process that brings about change. At all times a dialectical tension exists between efficacious and entertainment tendencies’ (Schechner, 1976: p. 76). The types of examples that McKenzie and Schechner use are primarily drawn from the theatre and performing arts in their relationship to culture. Although these are quite different spheres from where the issues under consideration in this thesis lie, there are important lessons from this body of work.

This is eloquently elaborated by Stern and Henderson; ‘performance incorporates a whole field of human activity...in all cases a performance act, interactional in nature and involving symbolic forms and live bodies, provides a way to constitute meaning and affirm individual and cultural values’ (Stern & Henderson, 1993: p. 3). Performance therefore does social work by constituting meaning and affirming values. This means that we cannot just look at the actions (and interactions) of individuals and organisations as being primarily motivated by rational motives. Their meaning goes beyond this. If we apply these notions to health and social care partnerships the implication is that the decision to collaborate with partners might not be as straightforward, rational or benign as it is often presented to be. There may be strong and compelling reasons to collaborate beyond simply a desire to improve service user outcomes. This thesis develops this notion. Given that there is little consistent and clear data about the efficiency and effectiveness of partnership, is there something important in terms of the cultural performance – the efficacy – of this concept that has driven interest such a high level of activity in the name of health and social care partnership.

The term partnership itself has a high degree of efficacy in an English context. As such it is often unquestioned and is assumed to be a public good. Dictionary definitions of partnership tend to be associated with the business of commercial contracts (perhaps unsurprisingly, given the dominance of economics in this sphere). Synonyms such as cartel, affiliation and conglomerate frequently appear alongside partnerships; but these are also joined by others like band, body, brotherhood, chumminess, clique, club, crew, fraternity, gang, help, mob, sharing, sisterhood, sorority, union etc. It is this latter set that denotes something quite different to a formal business arrangement.

In cultural terms, partnership tends to denote long standing relationships not necessarily bound by contracts, but often linked with notions of kin, family or even romance. That is, these types of definitions look very similar to the descriptions of networks set out earlier in this chapter. The term partnership has hugely positive connotations in socio-cultural terms, linked to notions of familial relationships. Glasby and Dickinson (2008) argue that this may be why some arrangements which might more accurately be termed market-based relationships (for example, public-private partnerships) are described as “partnerships”. Both can involve long-term relationships, but in being called a partnership (rather than a contract) this sounds more attractive and politically acceptable. This thesis proposes that, in addition to being vague and definitionally slippery, the term partnership has become so widespread precisely because it has a high degree of efficacy (cultural salience).

Under these terms, partnership might be considered a keyword. Raymond Williams famously defined ‘community’ as: ‘the warmly persuasive word to describe an existing set of relationships, or the warmly persuasive word to describe an alternative set of relationships. What is most important, perhaps, is that unlike all other terms of social organization...it never seems to be used unfavourably, and never to be given any positive opposing or distinguishing term’ (Williams, 1975: p. 76). Williams suggests that keywords usually have two main characteristics. Firstly, they are capable of incorporating multiple meanings (which might even be contradictory), but certainly these meanings often bear little relationship to each other. Secondly, the connotations of keywords are usually positive and difficult to argue against.

Partnership is used to denote public-private partnerships, hierarchical ties within care trusts, the relationship between citizens and the state and the organic, relational ties that one may find for example in voluntary and community sector organisations. These are all very different types of relationship and interpretations of this term - and yet they are all still called partnerships. Further, as the quote from McLaughlin at the start of this chapter suggests, partnership is difficult to argue against. Being against partnership would be akin to being against choice or against empowerment. By calling something a partnership this sets the expectation that this is a 'good thing', without necessarily being specific about how or why that may be so.

One of the early examples of an effective partnership set out by the Department of Health was that of Somerset which was the first integrated mental health organisation established in England. A review of the mental health services in Somerset in 1996 had revealed a series of problems in the local area, ones that were largely familiar across other areas of the country as well at that time. The response was to establish a joint commissioning board (JCB) and to integrate provision by establishing Somerset Partnerships Health and Social Care NHS Trust. The Trust became the first NHS provider organisation in England to employ and manage local authority social services staff and it also took over responsibilities for facilities and budgets which had previously been the responsibility of the local authority. Although by 1999 many areas in England had joint commissioning arrangements, in creating the integrated provision this made Somerset unique.

Edward Peck and colleagues (2001; 2002a; 2002b) evaluated this organisational innovation and found that the Trust and the JCB were established without apparently

reducing the quality of services in the local area which is an achievement in itself (particularly when compared with results from the commercial sector - see Field & Peck, 2003; Peck *et al.*, 2006). The JCB was deemed to make an important contribution to the local system:

'First it was the forum within which inter-agency partnership was publicly enacted. Second, it was the vehicle for sustaining the commitment to mental health of senior players. Third, it brought added elements of openness and public accountability to the commissioning and providing of health and, to a lesser extent social care...However, it is important to acknowledge that these contributions were as much symbolic (i.e. in the fact of its existence) as in the nature of the decisions that it took' (Peck *et al.*, 2004: p. 47)

Yet the establishment of the Trust was viewed much more dimly, stating:

'the combined Trust did not appear, by the conclusion of the evaluation period in July 2001, to have delivered any significant benefits that had not been delivered elsewhere in England without the transfer of social care staff to NHS employment. This is not to say it did not achieve change (e.g. improved care co-ordination within co-located teams). However, there is no way of knowing whether comparable change would have been achieved in Somerset without the combined Trust, although it is arguable that the acknowledged quality of leadership within the Trust would not have been attracted without the novelty of that combination' (p. 47).

The view of Peck and his colleagues was that the JCB had made a useful contribution, but predominantly in the form of its symbolic value rather than in terms of service user outcomes (and similar observations are made by Freeman & Peck, 2007 in another study of a joint commissioning board). The integrated provision was judged

to have produced little benefit that could not have been made in the existing system without such a large amount of disruptive change. There were three major areas noted where problems seemed to exist for mental health service users in Somerset prior to the change of management structures: level of communication between staff and service users in the process which led to buildings being closed; the quality of inpatient services; and service users' knowledge of their care plans. These were not new problems which arose as a result of the partnership, but had been endemic in the area for some time. None of these issues were addressed through the creation of the JCB or the Trust.

The real strength of the new arrangement seemed to exist in it being different to the types of arrangements which existed in the rest of the country as this had attracted particular individuals to its leadership cadre. The very success of this partnership was judged on the fact that it was innovative and not necessarily that it had led to differences in the quality of services. The arrangements were seen as good due to a normative judgement about innovation and integration. Somerset was lauded as a national example of good practice by central government (see Department of Health, 2000) and the types of arrangements that other mental health services across England should be aspiring to.

Yet, if Somerset is a beacon of best practice then this begs the question as to whether partnerships are really driven by the aim of improving service user outcomes? Somerset was judged a success in the sense that it created structural change and without too much disruption to services. Yet if this has not improved effectiveness or efficiency to any great degree then why was this example so lauded. In fact, why did

partnership remain so important and so centre-stage for the next decade and more? This thesis argues that the cultural performance of partnership is crucial in demonstrating the answer to this. Health and social care communities were told that they should be delivering high quality services in different ways to the past. Partnership therefore became a mobilising force in driving processes of change and modernisation across England. Under the guise of improving service user outcomes partnership has been used to drive significant organisational changes which otherwise may have been resisted. This is the line of argument developed further in the next section and throughout the thesis.

1.4 A performative perspective on partnership

Despite the many calls for health and social care agencies to work together, there is very little empirical evidence which demonstrates unequivocally that partnerships have improved outcomes for service users (let alone the wider population). If partnership is considered an improvement mechanism to bring about particular ends we might consider this problematic; particularly given that ‘evidence-based principles are at the heart of the Government’s reform agenda for better policy making and policy implementation’ (Cabinet Office, 2003: p. 17).

Some commentators have attributed this lack of evidence to the difficulties involved in researching partnerships and making a clear link to service user outcomes (e.g. Hudson & Hardy, 2002). One of the reasons often cited for the difficulty in researching partnerships is a lack of definitional precision. This is thought to be problematic in establishing the impact of “partnership” as it is difficult to be sure that

we are comparing “like” with “like” (Glendinning, 2002). Against this background, some researchers (e.g. Stein & Rieder, 2009) have argued for a more finely grained typology of partnership where the various characteristics of agencies and interactions might be compared with one another so that accurate statements can be made about the particular features of partnership. Yet such an argument has an inherent logic that contains a particularly linear notion of policy analysis and organisational action.

Indeed, research into health and social care partnerships has typically been based on assumptions which are consistent with linear and instrumentalist models of policy analysis. According to these types of analysis the lack of evidence of the effectiveness of partnership working indicates a conclusion of “failure”, either in terms of the construction of the policy or in the process of its implementation. Hill and Hupe (2002: p. 11) argue that ‘talking of an ‘implementation failure’ or implementation deficit’ means giving a normative qualification as a result of a comparison between what is observed and what is expected, where the latter is defined in terms of the values either of the observer or of one or more of the actors involved in the process’. In recent years we have started to see these types of normative qualifications being made in relation to the concept of partnership. Shortly after New Labour came to power the Audit Commission (1998) was incredibly positive about the potential of partnership arguing that ‘Partnership working is a potentially powerful tool for tackling difficult policy and operational problems that local agencies face. It can also be a productive way of achieving more efficient and effective use of scarce resources’ (p. 5). However, by 2005 it had become concerned about partnerships, remarking on their ability to ‘generate confusion and weaken

‘accountability’ (p. 2). In just seven years partnerships had gone from being seen as a way to overcome operational and financial problems to being inherently dangerous:

Partnerships also bring risks. Working across organisational boundaries brings complexity and ambiguity that can generate confusion and weaken accountability. The principle of accountability for public money applies as much to partnerships as to corporate bodies. The public needs assurance that public money is spent wisely in partnerships and it should be confident that its quality of life will improve as a result of this form of working...Local public bodies should be much more constructively critical about this form of working: it may not be the best solution in every case’ (Audit Commission, 2005: p. 2).

More recently, the Audit Commission (2008) reported on an evaluation of children’s trusts and similarly discovered that ‘there is little evidence that children’s trusts, as required by the government, have improved outcomes for children and young people or delivered better value for money, over and above locally agreed cooperation’ (p. 3).

The Audit Commission’s concerns have also been reflected across other areas of government as well as through practice and the findings of academics. At a practice level, a number of concerns have been raised about health and social care partnerships. In Wiltshire, financial difficulties and an apparent breakdown in communication between health and social care led to the dismantling of longstanding partnership arrangements and a high profile media discussion (see, for example, O’Hara, 2006). In Cornwall, inspectors found evidence of abuse and poor practice in a number of learning disability services. Although the Cornwall services were provided by a ‘Partnership Trust’, the inspectors concluded that ‘working relations between the trust and Cornwall County Council have been poor for a considerable time’ (Healthcare Commission/CSCI, 2006: p. 7).

In Manchester, an abuse scandal in a newly formed care trust prompted significant criticism from national inspectors, who questioned the readiness of previous organisations to form such an organisation, expressed concerns over relations between the care trust and other partners, and argued that the process of forming a care trust may have detracted senior management time away from service issues and quality of care (Commission for Health Improvement, 2003). In Barking and Dagenham, the local authority and PCT had initially appointed a single Chief Executive of the PCT/Executive Director of Health and Social Care, yet this broke down after a negative star rating of the PCT amid significant negative media coverage (see, for example, Batty, 2003).

Scandals over safeguarding and disagreements over finances between health and social care organisations have been endemic for a significant period of time. In none of these cases were these difficulties directly attributed to the fact that they took place in a partnership. The Cornwall case had shades of Ely Hospital (see, Robb, 1967) and other scandals which have periodically emerged since the 1960s. Arguably, these issues do not necessarily directly pertain to the concept of partnership any more than “better service user outcomes” do. However, there is some evidence that the concept of partnership is starting to come in for criticism. With staff members being increasingly compelled into partnership-related activities but all the while little evidence of the impact of partnerships and negative reports about this way of working in everyday practice and the media, Armistead and Pettigrew (2004) argue that:

‘It is important to recognise that the very term “partnership” might increasingly be perceived pejoratively, synonymous with lengthy, fruitless

meetings forced upon unwilling organisations by powerful external agencies prompted by government policy' (p. 574).

In being constructed as 'a good thing' without every defining what that 'good thing' might look like in practice, there is a risk that partnerships are seen to have failed because they have not solved problems that have recurred for decades.

The efficacy or cultural salience of the term partnership has often been implicit or taken for granted to some extent, yet it is crucial in the ability to engage health and social care organisations and professionals with delivering their difficult agenda. Yet, within recent months the language of joint working has begun to change, with much less reference to partnership (beyond options for funding mechanisms in social care) in recent government documents and more use of the terms integrated care and joint working (e.g. Secretary of State for Health, 2008; Secretary of State for Health, 2009). Local health and social care communities are becoming more sceptical about the value of partnership working. This is encapsulated by Powell and Dowling (2006: p. 305) who surmise that partnership working represents 'the undefinable in pursuit of the unachievable' – while 'there is no shortage of advice on how to 'do' partnerships... with lists of drivers, building blocks, and components..., the validity and reliability of this input into 'evidence-based' policy making is less clear'. Although central government has claimed to be committed to evidence-based policy and practice, there is little empirical evidence to link health and social care partnerships and service user outcomes. Moreover, the experience of front-line staff has, as suggested above, on occasions been far from positive. Yet partnerships continue to proliferate contemporary policy, with still further exhortations for 'more joined up working' (Secretary of State for Health, 2009: p. 11).

Table 1.3 sets out the evidence that has been discussed in this chapter. This table clearly demonstrates that the evidence pertaining to measures of efficiency and effectiveness is hardly definitive. Although at a local level some specific services may indeed be targeted towards working together in order to improve some aspects of care the evidence for partnership in a broad sense is found lacking. This thesis argues that this is because ultimately partnerships have never been solely concerned with service user outcomes as an instrumental tool of improvement. At a national level the concept has been invoked because of its cultural value and presented as a way to encapsulate a whole range of political, institutional and structural changes which were might otherwise be resisted. Given the cultural salience – or efficacy – of the term partnership it has been cited and (re)cited nationally and locally under the guise of improved service user outcomes, but in its iteration and reiteration actors have found space instead to invoke this term as a way of achieving rather different types of ends in practice.

Table 1.3: Summary of evidence of partnership performance

Type of performance	Evidence
<i>Efficiency</i>	<ul style="list-style-type: none"> • Partnership ‘costs before it pays’ and it is difficult to give an accurate figure due to all the ‘invisibles’ that need to be quantified (Leutz, 1999). • In structurally integrated teams (e.g. PRISMA, Darlington experiment) some evidence of cost savings where downward substitution takes place, although only effective where financial incentive (Johri <i>et al</i>, 2003). • Some early evidence of efficiency savings through wider partnership programmes – e.g. Total Place although questions regarding sustainability. • What proves to be efficiency savings for partnership might have knock on effect to other areas of public sector, e.g. referral threshold criteria. • More effective joint work might actually reveal more need which is potentially more costly in the short term.
<i>Effectiveness</i>	<ul style="list-style-type: none"> • Some evidence of impact on functional indicators (On Lok, PRISMA), but little of clinical indicators – although series of questions pertaining to methodological reliability. • Some evidence of individuals supported in community setting longer before being institutionalised (e.g. On Lok, Vittorio Veneto and Rovereto). • However, some projects show increased institutional care (Social HMO, Wiltshire) suggesting greater sharing of information and some possible lowering of risk thresholds. • Some evidence of improved service user satisfaction (e.g. PACE), although not across all service user groups. • Easier self-referral processes and quicker referral processes (e.g. Wiltshire).
<i>Efficacy</i>	<ul style="list-style-type: none"> • Partnership as a key word with a high degree of cultural salience • Value of new partnership arrangements is in their innovativeness, which attracts in quality leadership (e.g. Somerset). Symbolic value of arrangements. • “Partnership” starting to experience perceived loss of faith through negative media reporting, scandals (e.g. Cornwall) etc. although the problems which are being linked to partnership are not expressedly “partnership” issues but long-term endemic problems within health and social care communities.

The political discourses of partnership have been used in governance terms not simply as a movement from hierarchical or market-based relationships to network forms; but instead, as an active tool in influencing actors to engage in processes of change through altering perceptions of what and how health and social care services should be delivered. However, there is a danger in relying on the efficacy of a concept in order to usher in a range of “modernisation” processes. Not only is there a lack of universal and generalisable “scientific” evidence about the impact of partnerships on service user outcomes, but different audiences will judge this term according to what is consistent with their own values and cultures. To this extent, partnership is becoming tarnished given that it has been criticised on academic, practice and regulatory fronts. Based on an interpretive analysis this thesis argues that most significant impact of English health and social care partnerships is in their value as a means of cultural performance. Ultimately the very strength of “partnership” lies in its lack of finality when considered as a political discourse.

1.5 Thesis structure

Having articulated the line of argument that is set out in this thesis, this final section provides a brief overview of which each of the chapters contributes to further developing and illustrating this line of reasoning.

Chapter One has briefly mapped out an account of the research programme and set out what this thesis adds in terms of original contributions to knowledge.

Chapter Two sets out the theoretical underpinning of the thesis. Whilst studies of “partnership” have tended to adopt rationalist assumptions about the nature of policy implementation, this thesis adopts a position which is informed by interpretive traditions. The chapter sets out the rationalist model of policy and the critiques of these approaches which are posed by interpretive traditions. The chapter provides an overview of theoretical concepts that are helpful in terms of this research, such as: frame analysis, institutional theory and critical discourse analysis. The chapter sets out the strengths of these approaches and what they might add to the research, but also the limitations inherent within them. In doing so the chapter makes the case for the theoretical framework of cultural performance which is adopted as the underpinning theory within this research.

Chapter Three applies the notion of frame analysis to a review of health and social care partnership policy. The account of the policy context offered differs from the standard accounts which tend to chronologically chart the historical development of collaboration between health and social care agencies. Instead, this chapter identifies the four dominant frames which explain why it is that health and social care partnerships exist and what it is that partnership should achieve. Although central government has predominantly cited improved service user outcomes as the motivation for partnership, this does not appear as a central concern within the majority of these frames. This chapter therefore argues that service user outcomes are therefore not the sole driver of partnerships but tend to be deployed in a rather more rhetorical matter.

Chapter Four sets out the methodology employed within this programme of research. In doing so it sets out a case for employing exploratory case studies as the primary means of investigation. The chapter also outlines the POET process and how this tool was designed and developed and what research was involved in the different case study sites.

Chapter Five sets out the findings of the research. The chapter provides an overview of the case study sites, the process through which access was negotiated and the key messages from the research which took place in each of these locales and the common themes across the sites. Although there is some significant variation in terms of the characteristics of the sites, the research experience was similar in a number of respects: the most significant being the inability of a range of stakeholders to identify what they were trying to achieve in terms of outcomes for service users and carers. At consecutive sites although stakeholders stated that they were clear what it is that the partnership was ultimately set up to achieve, they found it rather more difficult to articulate this with any more specificity than a series of ultimately organisational (as opposed to service user and carer) outcomes.

Although these partnerships were claimed to be driven by the aim of improving service user outcomes, these observations suggest that their local enactment was rather different. It appeared that there were other factors driving local changes that were not being explicitly articulated. Indeed, the very inability to conduct the second phase of research at two of these sites suggested that there were very different drivers present than would be anticipated from the national policy context. Partnership was being used as a means of framing a series of changes and engaging a variety of

stakeholders towards some specific local changes, and actions that might otherwise have been resisted.

Chapter six discusses the findings set out in chapter five in more detail and with reference to wider literatures. This chapter argues that what the case study sites illustrate are the use of the notion of partnership not simply as a tool of improvement to bring specific and identified about changes in service user outcomes, but also as an active tool of governance. In this sense the role of partnership is not as a specific mode of governance, but as a technique of framing that might be engaged as a means to mobilise a variety of stakeholders to become involved in a particular course of action or set of activities. This analysis demonstrates the performative value of partnership and one which goes beyond existing concepts of the role of partnership in processes of governance.

Chapter seven summarises the arguments set out in the thesis. It provides a succinct account of the research undertaken for this thesis and the original contributions to knowledge that this provides. In setting out its conceptualisation of partnership, this thesis poses a challenge to the existing research and evidence base surrounding partnership, suggesting that interpretive and performative analyses may be more suited to this area of academic endeavour. As such, this chapter concludes by setting out areas for possible future research.

1.6 Chapter summary

This chapter has provided an introduction to this thesis defining the key terms partnership and governance and setting out the existing evidence about the impact of partnership. This chapter argues that health and social care partnership is not a coherent model of service improvement, but instead is a discursive entity which is open to political manipulation in the processes of governance. The chapter has set out an account of the overall line of argument set out and mapped out the structure and content of the thesis highlighting the original contributions to knowledge that this thesis makes.

Chapter Two: Interpretive and performative policy analysis

'Partnerships should avoid spending too much time looking at how well the partners are interacting: the point of forming a partnership is to improve performance, and this should principally be measured through the eyes of service users, citizens, and other stakeholders' (Audit Commission, 1998: p. 32).

2.1 Introduction

Aside from being rather ambiguous, the quote from the Audit Commission set out above suggests that partnership is a specific means for bringing about improvements from the perspective of the service user. Yet, as chapter one illustrated, there is little evidence to support this link. Some commentators (e.g. Banks, 2002) have suggested that this lack of evidence indicates policy failure at worst, or at best some kind of deficit in terms of implementation. Implicit in these arguments is a rationalist model where policies are introduced as specific means to bring about identified ends. According to such a perspective, health and social care partnerships have been introduced in order to improve service user outcomes, but given a lack of evidence that this has been achieved this indicates failure either in terms of the policy or its implementation.

However, there are other approaches to understanding policy which go beyond the rationalist, normative and empiricist kinds of enquiry which underpin much of the

work that has been conducted into studies of health and social care partnership. The interpretive turn has drawn attention to the importance of socio-cultural practices and the ways in which realities are constructed. Social policy is understood as a discursive construct which is open to multiple interpretations, rather than a simple or straightforward model which is subject to rigorous causal theory. This chapter outlines the contours of the debates between traditional (rationalist) concepts of policy analysis and those traditions associated with an interpretive turn. The chapter provides an overview of a range of different theoretical positions and the insights that these offer the study of partnerships but also their limitations. Through this process, the chapter outlines the case for making a cultural account of governance through partnership and sets out the theoretical position adopted within this thesis.

2.2 Rational models of policy analysis and the interpretive turn

Dunn (1981: p. 35) defines policy analysis as, ‘an applied social science discipline which uses multiple methods of inquiry and arguments to produce and transform policy-relevant information that may be utilized in political settings to resolve policy problems’. Early scholars of policy analysis such as Laswell (e.g. 1941), set out grand visions that this field would be truly multidisciplinary, anchored in human values and sensitive to local context, aiming to aid and develop the evolution of democratic governments in liberal societies (Torgerson, 1985). However, what has emerged as the dominant approach in this field is arguably more technocratic and empirical in practice and largely unrelated to the principles of democracy which Laswell sought. This section gives an introduction to the development of rationalist approaches in the analysis of policy. It is necessarily brief given the constraints of

this thesis, but aims to map the main contours of this vast terrain in preparation for the critiques of these approaches which follow (for more in-depth accounts see, Hill & Hupe, 2002; Fischer, 2003; Hill, 2005).

Characterised by the neopositivist and empiricist methods which dominated many areas of social science research through much of the twentieth century, the focus of mainstream policy analysis has tended to be on generating rigorous quantitative data, objectively separating facts and values and searching for generalisable findings which have validity outside of the social context they were forged in. In this sense, policy analysis has often been seen as a 'rational model' that might inform decision-making - or as Stone (1988) terms this, the 'rationality project'.

Rationalist models of policy analysis are typically deeply rooted in a stages model (e.g. Jenkins, 1978), where the existence of a problem is empirically established, at which point goals and objectives are formed and an optimal solution may be found. The solution is settled upon by considering the various alternatives and their consequences and then selecting and implementing the most effective and efficient option. What this model essentially strives to achieve is the translation of political and social issues and problems into technically defined ends that can be delivered through administrative means. This kind of technocratic approach has long dominated (and arguably still continues to dominate) much policy analysis (Peck & 6, 2006). Rationalist models of policy analysis typically separate out policy formation and policy implementation. Policy therefore, is ultimately concerned with selecting goals and the means of achieving these goals, embodying a strong sense of cause and

effect (i.e. if we do x , then y will be the outcome). Implementation is deemed to have occurred when policy-makers' intentions have been carried out.

In the early 1970s, beginning with Pressman and Wildavsky's (1973) seminal text *How great expectations in Washington are dashed in Oakland*, the assumptions of a rationalist model of policy analysis started to be challenged. These authors observed that what was happening on the ground often differed from what policy-makers had articulated. Pressman and Wildavsky noted the extensive range of stakeholders involved in the implementation process and observed that these do not always work together as easily or effectively as policy-makers envisage. These commentators argued that without strong links between all the partners involved in the implementation process then policy would not be delivered in the way intended. There would therefore be "gaps" or "deficits" in implementation. Of course, implicit in this judgement is an assumption that policies are coherent across governments a point which subsequent research has often challenged (e.g. Hill & Hupe, 2002). However, in focusing on the distance between policy formulators and policy implementer, Pressman and Wildavsky highlighted that a range of issues might confound policy intentions in practice. Examples given include: unforeseen local contextual issues; the time it takes to implement policy; or a failure to sufficiently articulate the "problem" or "solution".

Following the work of Pressman and Wildavsky, a whole hive of research activity emerged that sought to study the "gaps" between those making policy and those implementing it. Often this type of research adopted a prescriptive approach, offering advice on the ways in which gaps might be "prevented" (e.g. Sabatier & Mazmanian,

1979). Colebatch (2002: p. 53) observes the literature as, ‘a little depressing, because it seems to be largely about ‘implementation failure’’. The implicit assumption is that policy should be “top-down” in the sense that policy-makers should take responsibility for the formation of policy; local actors and services should then put these actions into place in the manner intended (Hill, 2005). Rationalist approaches therefore strive to address complex issues through better programme design and the improved management of local services. Inspired by “bottom-up” perspectives of policy, some commentators noted that policies do not always appear as a coherent fully-formed model as rationalist perspectives would suggest. The refinement of policies emerges through the course of interaction between stakeholders within local settings as Hood (1976) highlighted in his critique of the ability to “perfectly administer” policies within complex environments. At this point the study of implementation started to see a shift in terms of its focus. Given that the formation of policy is not as easily separated from its implementation as the rationalist models suggest policy studies began to highlight the importance of socio-cultural factors within these processes.

Rationalist approaches to policy analysis and implementation were heavily influenced by positivist approaches to the study of social phenomenon and were critiqued from a number of angles by the postpositivist turn in social science. This postpositivist (also known as postempiricist) turn was inspired by a range of movements (e.g. critical theory, post-structuralism, social constructionism, postmodernism and discourse analysis) that all operate in a variety of different disciplines and fields. Where these different movements coalesce around critiques made on epistemological grounds produced an interpretive turn in policy analysis. Postpositivist approaches reject the

notion of “traditional scientific principles” and the idea that a unified understanding of scientific methodology can be applied to all research questions (Bohmann, 1991). They reject the notion of objective “facts” about the nature of the world, believing that all observations of the world rest on interpretations. Everyday life is understood as embedded in social and cultural meaning which is produced (and reproduced) by discursive practices which are outside of actors’ choosing or making (Fischer, 2003). Postpositivist approaches reject technical rationality and its attempts to remove emotion and conflict from the study of policy. Subsequently, interpretivist scholars have sought to demonstrate the ways in which seemingly neutral “facts” or categories mask power structures and seek to shape our assumptions about the nature of the world (e.g. Foucault, 1977; 1990; 1992; 1998).

An important advancement of the interpretive turn was to recognise that the social world is not fixed and objective but is framed through discourses of actors. Neutral, objective and “scientific” analysis of policy is therefore seen as impossible; all empirical assertions are essentially contestable. Policy analysts have a role in explaining and debating the many potential dimensions which will inevitably relate to most policy issues (Hawkesworth, 1988). This turn also addresses the distinction between policy formation and implementation, viewing this as much less distinct and clear-cut than the rationalist model would seek to suggest. Freeman (2007) sums up this position arguing that rationalist models make the assumption that ‘the relationship between a problem and a policy may be formulated in terms of an explicit theory of cause and effect, which will then be applicable to other similar instances of a problem. It privileges scientific method over other ways of knowing, and it predicated on the

existence of universal reason' (p. 478). Interpretive approaches suggest that cause and effect is rarely as straight forward as rationalist models propose to be the case.

Peck and G (2006: p. xvi) sum up the challenges to rationalist perspectives of policy implementation arguing that, 'the concept of delivery when applied to the local implementation of national policy, is a profoundly misleading one. "Delivery", we argue, suggests that the role of local public sector managers and professionals is to simply adopt policy that is promulgated by government'. Peck and G argue that policy implementation is less a matter of local agencies "delivering" policy as one would deliver pizza and is more akin to midwifery. In doing so, Peck and G highlight the arguments that academics such as Lipsky (1980) have set out which illustrate the co-productive nature of policy and the autonomy which professionals (particularly in the fields of welfare services) have in engaging with processes of implementation. Interpretive analysis argues that policy may be open to a multitude of interpretations and this can be particularly pronounced in areas like health and social care, where there are frequently a range of competing values present. Andrew Wall (who was a senior NHS manager), sums this up, writing:

'Managers are faced with contradictory pressures: obedience to their masters, support for clinicians, maximising public benefit, respecting the rights of patients; all these can be, at times, in opposition. [...] Nevertheless they may be hesitant at declaring their own values, fearing derision for being too subjective and not therefore exemplifying the rational paradigm associated with managerialism' (Wall, 1998: pp. 24-25).

Given the range of stakeholders who are actively involved in policy processes, it is not helpful to think of governments as the creators and disseminators of goals and

actions which are simply put into practice by local agents. Implementing policy is not, therefore, the passive affair that a pizza metaphor would suggest, but requires much more agency on the part of a range of stakeholders as the midwifery analogy indicates.

Bacchi (1999: p. 18) eloquently sums up the interpretive critique stating; ‘theorists in this category object to the impression conveyed by technical rationalists that policy is a straightforward matter of finding technical answers to readily identifiable problems. They are much more sensitive to the give and take of politics, to the shifting of positions and perspectives, and to the role played by politics...Importantly they address the need to talk about the role of values in policymaking’. Osborne’s account of New Public Governance set out in chapter one suggested that governments of the past were viewed as giving orders but now they should be primarily concerned with negotiation. If this is true, then increasingly the task for governments is in weaving together the activities of a range of participants. Policy analysis therefore becomes less concerned with tracking adherence to a set process as associated with the rationalist model and pertains more to the study of social action (Colebatch, 2002).

Within the interpretive turn there is a range of ways that we might consider the “study of social action”. Frame analysis, institutional theory, critical discourse analysis all have important insights into studying partnership beyond traditional and rationalist types of approaches but this thesis ultimately finds these approaches lacking in some sense. The remainder of this chapter sets out the insights that these different traditions provide along with their limitations and in doing so extends the case set out in chapter one for studying partnership from a cultural performance perspective.

2.3 Frame analysis

Interpretive approaches argue that it is important that we consider socio-cultural processes with the analysis of policy and the way that individuals make sense of their every day lived experience. Fischer (2003: p. 49) argues that ‘rather than seeking proofs through formal logic and empirical examination, the investigation of social action requires the use of metaphoric processes that pull together and connect different experiences based on perceived similarities’. The type of approach that Fischer is advocating stresses the discursive construction of reality, which is qualitatively different from that which empiricist studies of public policy have traditionally tended to offer. Frame analysis is one approach that has been used in order to try and understand how “reality” has been constructed for and by individuals.

As this section will illustrate, frame analysis is helpful in illustrating the range of different perspective that might be present in any situation. It has been used as a way of problematising notions of “problems”. As already argued, in traditional policy analysis there is some debate over the potential solutions, but the singularity of problem is normally agreed upon. Frame analysis illustrates the range of perspectives that exist in terms of what the problem actually is that this policy is responding to. In chapter one it was suggested that partnerships might not ultimately be driven by a desire to improve service user outcomes, so chapter three uses frame analysis to examine the policy context and explore the types of problems that health and social care partnerships have been seen as a response to.

Frame analysis has a long history deriving originally from sociological and anthropological studies (e.g. Bateson, 1972; Goffman, 1974) and subsequently pioneered in public policy analysis by academics such as Donald Schön and Martin Rein (e.g. Rein & Schön, 1977; 1993; Schön & Rein, 1994). The notion of a frame is essentially a metaphor which is used in interpretive studies as a principle of organisation (Yanow & Schwartz-Shea, 2006), ‘which governs the subjective meaning we assign to social events’ (Goffman, 1974: p. 10-11). Framing emphasises the ways in which actors make sense of social and political “realities”. The processes of framing highlight particular social and political views, whilst precluding or occluding others through the practices of meaning making. Frames direct attention towards particular features of social and political landscapes and away from others, shaping the possibilities for action. Framing, then, is a principle through which fragments of information can be made into a structured and meaningful whole for its intended audience.

Schön and Rein (1994) argue that public policies depend on frames to supply them with underlying structures of beliefs, perception and appreciation. Frames define not only what the problem is, but also in this process which forms of action need to be taken to deal with this problem. A frame provides ‘conceptual coherence, a direction for action, a basis for persuasion, and a framework for the collection and analysis of data – order, action, rhetoric, and analysis’ (Rein & Schön, 1993: p. 153). As Atkinson (2000) illustrates, ‘[I]n relation to policy, particular narratives structure and limit what may be told or said and how reality is thought represented and acted upon...narratives are not free floating but linked to political formations and institutional organisational forms’ (p. 213). Atkinson continues to surmise that,

‘Political actors deliberately portray them [problems] in ways calculated to gain support’ (p. 214).

Thus, analysing frames involves looking for patterns in the way actors collectively put forward views on specific issues they are engaging in and how contending frames interact in processes of communication between groups. It involves the construction of “story-lines” in the terms of Hajer (1993). Frame analysis does not simply involve analysing the content of frames. Frame analysis is much wider, exploring the ways in which sensemaking takes place in relation to wider socio-cultural institutions (Weick, 1995). After all, ‘different people construct different arguments out of the same narrative’ (Fischer, 2003: p. 181). Of concern are not necessarily the frames of individuals, but how these are indicative of wider collective meanings.

As an example of this phenomenon, Hajer (1993) sets out the various discourses which are found in debates over acid rain. In doing so, he draws attention to the way that “wicked problems” are framed or formed and not simply “found”. These debates are described by Hajer as ‘story-lines’ in the sense that they are based on different interpretation of the ‘problem’ of acid rain. Where a schema of cause and effect of acid rain was identified, Hajer termed this a discourse coalition. Examples of discourse coalitions included a scientific discourse based on identifying ‘what it is’; an engineering discourse, based on ‘how it can be fixed’; an economic discourse, based on considerations of ‘what the cost is to society’ and a political discourse, based on ‘whether or not it should be tackled’.

Over time, debates over acid rain became incorporated into mainstream British politics where the problem shifted from being viewed as simply the problem of the 'expert technical' to one that was more widely owned because it is 'morally wrong' and inefficient in terms of society. The shift towards a concern with morality moved the debate on from being primarily driven by pragmatic and rationalist approaches to pollution, to one which became much more strategic and preventative in approach. In his examination of discourse coalitions, Hajer demonstrates that through the 'perpetuation of ideas' various actors might 're-produce practices without sharing their deep values each time' (p. 48).

The strengths of the approach of frame analysis are that it offers a way of trying to understand the many different positions and perspectives held by stakeholders in relation to a particular issue and therefore why particular solutions are put forward or accepted as legitimate means of action. However, frame analysis has been critiqued or questioned by a number of authors (e.g. Benford, 1997; Jasper, 1997) with Steinberg (1998: p. 847) outlining the difficulties with this approach and what he terms constitute the 'cracks in the frame'. One of the strengths of a framing approach is that it does not privilege one frame over another and suggests that all may coexist, but this is also one of the difficulties of this approach in practice. Frame analysis is not always clear about where various frames come from, how they are shaped or the influence that they have in practice. Oliver and Johnston (2000) illustrate a number of these critiques in writing about the difficulties in the relationship between frames and ideology. The main point of contention put forward by these authors is that it is not always clear in frame analysis how these everyday discursive structures relate to deeper socio-cultural structures. Whilst highlighting the many different discursive

constructions of “reality” within any one situation a framing approach has rather less to say about links to structure.

Frame analysis has been applied to a range of different policy contexts in empirical settings (e.g. Hajer, 1993; Linder, 1995; Dudley, 1999; Abolafia, 2004; Daviter, 2007), but has not been applied before to the study of health and social care partnerships. As described at the start of this section, frame analysis is employed in the following chapter to illustrate the range of problems that it is suggested that health and social care partnerships have been established to deal with. Although a useful tool in illustrating this array of problems, it says rather less about where these cultural norms come from in practice and how they are replicated. It is therefore a useful tool in this respect, but is insufficient in offering a complete account and needs to be complemented by other types of approaches. One theory which has much to say on the issue of culture and practice is institutional theory and the chapter turns to considering this in more detail in the next section.

2.4 Institutional theory

Institutional theory has been influential in the interpretive turn, particularly in terms of highlighting the impact which context has on implementation processes. There are various forms of institutional theory (for an overview see, Lowndes, 1996) but what these share at their core is a focus on aspects of social structures. Institutional theory considers how rules, norms and routines become established as guidelines for social behaviours, rejecting rational-actor models (particularly those associated with

classical economics) and seek to explain social and organisational phenomena through cognitive and cultural explanations (Powell & DiMaggio, 1991).

Institutional theory stresses the importance of “informal” social structures which develop within specific settings. As Selznick (1957: p. 5) defines, ‘an institution...is more nearly a natural product of social needs and pressures – a responsive adaptive organism’. Although Selznick’s work has been extensively critiqued since formulating this definition (see, for example, Hill & Hupe, 2002), the core component of his argument - that institutions should be seen as ‘cultural rules’ - remains relevant. Institutions are often taken for granted within everyday life, much as they also are in aspects of the policy process where they may be seen as standard operating procedures.

Institutional theory argues that it is only by understanding cultural structures that we are ever able to intervene or try and influence the actions of individuals and organisations. As Immergut (1992: p. 63) describes, ‘institutions do not allow one to predict policy outcomes. But by establishing the rules of the game, they enable one to predict the ways in which policy conflicts will be played out’. Institutional theory has been used in organisational studies to explain why it is that organisations working in similar areas often develop comparable characteristics. DiMaggio and Powell (1991b) suggest that the emergent belief system about organisations supersedes any possible beliefs about the most effective ways of arranging particular organisational aspects. In other words, this proposes that in order to survive, organisations must conform to the rules and belief systems that prevail within that environment (Scott, 1995). In the context of this thesis, such an analysis is a helpful means of analysing

why it is that public sector agencies view partnership working as a way of overcoming difficulties which they encounter within their often quite varied contexts.

One phenomenon which institutional theorists outline, and is of note in this respect, is that of institutional isomorphism. DiMaggio and Powell (1991a) identify three types of isomorphism:

1. *Coercive isomorphism* which comes from political influence and the problem of legitimacy;
2. *mimetic isomorphism* which comes from standard responses to uncertainty; and,
3. *normative isomorphism* which is associated with professionalisation.

It is important to note that these forms of isomorphism are not mutually exclusive and one may shape the other(s) and vice versa. This analysis might be invoked to propose that collaboration does not simply take place because it is the most “effective” option available at that time, but because the institutional environment values these behaviours. If, as institutional theory implies, all organisations are influenced by the broader environment (institutional pressures), then forces inhibit the environment suggesting that at any time the range of options available to actors is restricted. Given this, the notion of framing becomes crucial in terms of the ways in which actors make sense of their environment. This has significant consequences for the “real” or perceived options for action available to actors within any particular time and place. Thus, interpretive policy analysis suggests that discursive practices shape the

behaviours of actors within institutions via accepted rules, means of assessment and emotional commitments to particular causes.

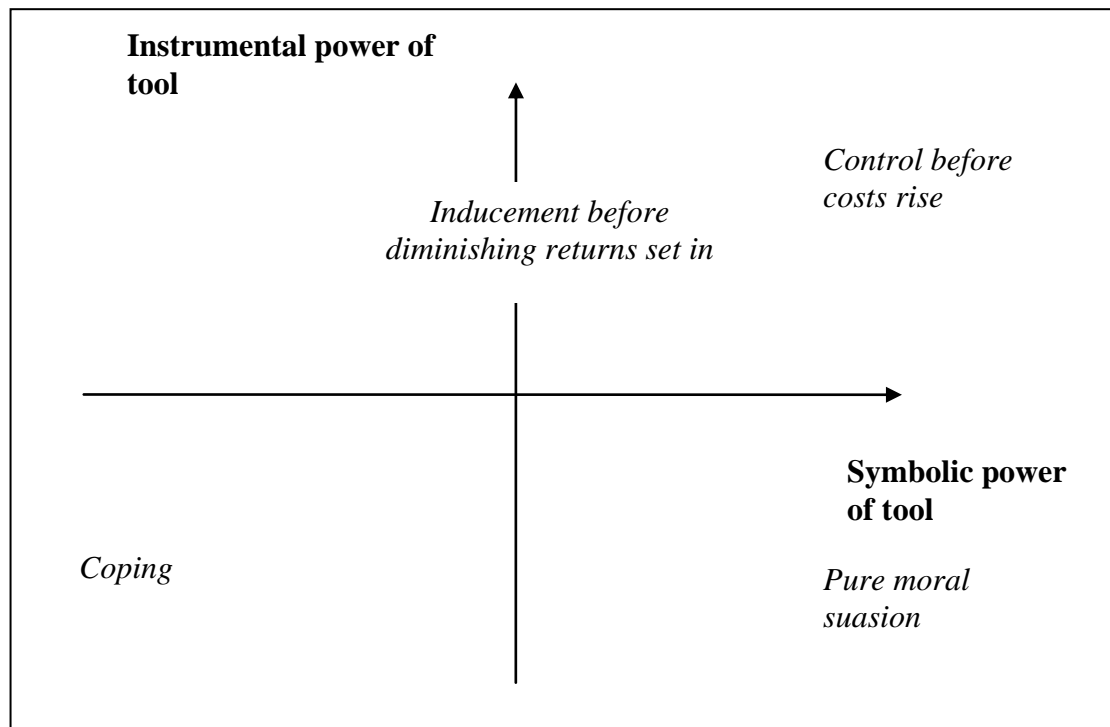
What is also common across interpretive policy analysis is the construction of notions of power. The top-down, rationalist models referred to above tend to conceptualise power as a resource where one agency or individual can be said to have more power than another. Power is often seen as a coercive force within these models with one individual or agency forcing another into action by the use of their power. However, following academics such as Lukes (1974) and Clegg (1989) the interpretive turn conceptualises power as a relational element which is used in the very defining of interests; such that, *A* may exercise power over *B* ‘by influencing, shaping or determining his very wants’ (Lukes, 1974, p. 23) (for example, through framing a problem in a particular way). Picking up on this notion and drawing on a particular variant of institutional theory - neo-Durkheimian - Goodwin *et al* (2004) analyse a further implication of policy – its highly symbolic nature.

Goodwin *et al* (2004) analyse the ways in which different types of power is deployed in different types of networks and to what effect and map the tools required for the governance of, and management within, networks onto a matrix (Figure 2.1). What this demonstrates are the different tools of governance that are available with their associated forms of power; i.e. what they argue is that different forms of power are more or less successful when deployed within particular modes of governance. Thus, although there is a general presumption of an instrumental form of power within the rationalist policy models, this analysis suggests policy may also have highly symbolic powers which move individuals and groups into action through their moral suasion.

Although there is an inherent presumption in the rationalist model that policies are instrumental responses to problems, there is a significant history of the study of symbolic policy making. As Edelman (1971) observed, policy is sometimes made not as a real attempt to tackle an identified problem, but as an action to demonstrate that something is being done about a problem. It is argued here that this has been a particular feature in terms of health and social care policy under the New Labour administration.

Goodwin *et al's* (2004) analysis demonstrates the different means through which governments can compel organisations and agencies into action. According to these commentators, the symbolic meaning of control and inducement are importantly different. Control in this sense refers to the direct application of power or coercing action, often by the use of regulatory force or law. In terms of policy then, processes of control would be more akin to rationalist models where power is a resource. Inducement, however, refers to the impact policy might have in terms of shaping conceptions of what it is that individuals and groups want and need, not directly through the application of power, but by recourse to socio-cultural institutions and norms. In other words, outcomes are achieved not through top-down processes of inducement but by the deployment of what the mainstream organisational studies literature would consider “less formal”, relational sources of power.

Figure 2.1: Instrumental and symbolic powers of tools of governance: relationships between tools



(Goodwin *et al.*, 2004: p. 53)

The implications for this thesis are that the impact of policy is more likely to be in the interaction, dialogue and negotiation between stakeholders in defining terms, goals and outcomes than it is in delivering a specific improvement. Goodwin *et al* (2004) suggest that where control is used, this indicates that greater moral weight is attached by policy makers to the targeted risks and opportunities than the decision to use inducement. Goodwin *et al* give the example of radical environmental groups objecting to decisions made to substitute taxes on polluters or tradable pollution rights for older systems of coercive regulation. What these groups fear is not only that the inducements will be less effective, but that this signals a relaxation of social and political concern (p. 53). Thus, control can be seen at the level of its symbolic meaning, not as the limit case of inducement, but as the limit case of influence. If

policy serves not just as an instrumental means of bringing about specified changes, but as a symbolic tool of governance then the process of delivering public services is not simply a technical exercise. Given that we live in ever more diverse and pluralistic societies, ‘politics in modern democracy must accept division and conflict as unavoidable, and the reconciliation of rival claims and conflicting interests can only be partial and provisional’ (Mouffe, 1993: p. 113). Policies, therefore, are more than rational instruments; they embody particular values, and in so doing occlude others.

As earlier indicated, institutional theory has many variants so it is difficult to be definitive about this as a theory. However, it has been critiqued quite widely for having more of a static notion of power than has perhaps been outlined here. Studies of partnership have incorporated insights from institutional theory, most notably in the work of Janet Newman (e.g. 2001) but these have found the undifferentiated accounts of culture and static notions of power problematic. Given that newer variants of institutional theory (e.g. DiMaggio & Powell, 1991b) have also often been associated with notions of maximisation the insights that this type of theoretical base might provide has been fully realised.

2.5 Critical discourse analysis

Crucial to interpretive studies are the role of language and the impact of discourse. Language is a powerful constitutive force within politics which is used to construct and re-construct the world around us, rather than as a direct reflection of “reality”.

Interpretive approaches consider the formation of policy not as finding solutions to problems, but that in studying discourse this reveals the 'assumptions about the nature of the problem in any postulated solution. It is concerned with problem representation' (Bacchi, 1999: p. 2). The social world and the discourses surrounding it create political arguments that cannot be falsified or completely verified. As Fischer (2003: p. 87) argues, discourses 'condense large amounts of factual information intermixed with the normative assumptions and value orientations that assign meaning to them'. Interpretive policy analysts therefore ultimately suggest that a society of multiple realities and relative standards are all we will ever achieve (Edelman, 1988). 'The essence of policymaking in political communities [is] the struggle over ideas. Ideas are at the centre of all political conflict...Each idea is an argument, or more accurately, a collection of arguments in favour of different ways of seeing the world' (Stone, 1988: p. 11).

Yet, there is rather less agreement within the broad area of interpretive analysis in terms of how to study language and its relationship with underlying social and cultural structures. What this chapter has set out to demonstrate is that the types of theoretical frameworks that have been adopted to study policy have all been critiqued for their inability to sufficiently accommodate aspects of structure or of agency or the linkages between these. Whilst institutional theorists draw attention to the importance of social structure, they have been critiqued for providing insufficient space in terms of an account of agency. Similarly, where frame analysis offers a means of accommodating agency, it says rather less in terms of the role of structure in constraining or enabling the types of frames that adopted and reproduced.

Attempts have been made to join the micro and macro levels by understanding discourse beyond a little ‘d’ - which relates to language and social interaction – to also including big ‘D’ discourse which relates more to system of thought, ideas, assumptions, and practices (Alvesson & Kärreman, 2000). Critical approaches such as this seek to investigate how realities that are constructed through language, related to material practices and the complexity of power relationships within these conceptualisations (Zoller & Fairhurst, 2007). It is argued that studying Discourse can reveal much about the entrenched power relationships that exist within a particular system and structure particular interactions between stakeholders (and similarly might exclude others). Critical Discourse Analysis (CDA) attempts to achieve just this by concentrating on language and the ways that power relates to discourse (e.g. Fowler *et al.*, 1979; van Dijk, 1980; 1993). CDA is not specific school but brings together a range of different approaches that seek to explicitly recognise the impossibility of a “value-free” society and argues that science is influence by social structure and produced in social interaction. CDA focuses on the ways in which particular discourse structures are deployed in order to produce and reproduce social dominance.

CDA argues that language and power are entirely linked (Fairclough, 1989). An insight that this thesis has argued is crucial in thinking about health and social care partnerships. CDA is therefore a collection of approaches which seem to offer helpful insights into the relationships between partnership and discourse in relation to structures of power. Although critical discourse analysis offers a way of bringing together both quantitative and qualitative research, it has been criticised as being predominantly concerned with language at the expense of the material world (Kaplan,

1990). Whilst critical discourse analysis does draw attention to structures and power but most often at the level of text. As van Dijk (1998) argues, the relationships between discourse structures and the social context is not often made explicit and when it is most often appears in terms of knowledge and ideology. There is still somewhat of a gap between linguistic approaches to CDA and the more social approaches. The first tends to ignore the wider sociological and political science literatures, whilst the latter is often less detailed in terms of discursive analysis.

2.6 Cultural performance and partnership

This chapter has so far set out an overview of frame analysis, institutional theory and critical discourse analysis and argues that all are helpful in thinking about health and social care partnerships and their link to performance. Institutional theory is useful in highlighting the informal and cultural rules and suggests that change takes place according to logics of appropriateness and in order to win external legitimacy. Institutional settings define the kinds of actions and behaviours which are legitimate, but also how certain actions, deeds or word might be interpreted. However, institutional theories have come under attack for sufficiently dealing with the concept of power and treating culture in a rather undifferentiated way. Institutional theory offers a helpful account of structure – and one which is sometimes absent in accounts of frame analysis – but does so at the expense of undermining the agency of actors and at its most extreme giving way to organisational determinism (Newman, 2001). Institutional theory is helpful in giving due emphasis to the importance of the social structures that value partnership and legitimate it through processes or isomorphism and foregrounding issues of governance. However, a limitation is the inability to

explain why or how certain behaviours become institutionalised and how dynamic and open to revision these processes actually are. CDA is helpful in demonstrating links between discourse and relations of power, but is charged with focusing on the ideational at the expense of a more contextualised account of the world.

This thesis seeks to draw on insights from frame analysis, institutional theory and CDA under the label of cultural performance. Studies of cultural performance and associated concepts of “restored behaviour” (Schechner, 2003) offer insights into the processes of institutionalisation and the room for changes to structures and institutions through processes of citation and iteration. As Freeman and Peck (2010) argue, focusing on cultural performance is helpful as it: ‘explicitly incorporates temporal and inter-subjective dimensions of (dis)continuity, offering a course between determinism and voluntarism in cultural reproduction through notion of performativity, citation and reiteration’ (p. 32).

As chapter one argued, partnership is not a coherent or agreed upon concept or model and is therefore open to interpretation. This is problematic for Banks who remarks:

‘The term ‘partnership’ is increasingly losing credibility, as it has become a catch-all for a wide range of concepts and a panacea for a multitude of ills. Partnerships can cover a wide spectrum of relationships and can operate at different levels, from informally taking account of other players, to having a constructive dialogue, working together on a project or service, joint commissioning and strategic alliances’ (Banks, 2002: p. 5).

The crux of this argument is that the use of the term partnership to refer to many different types of relationship is problematic as it will ultimately lose salience as a

model. However, this observation mistakes the notion of partnership as being a specific device for bringing about improvement in services and service user outcomes. What is argued in this thesis is that partnership is a form of cultural performance, as opposed to a means-end mechanism of improvement. Insights from CDA suggest that there is a discursive component to partnerships in the sense that this concept is able to accommodate multiple ways of seeing the world in terms of why partnership is a necessary component of health and social care policy and the role of stakeholders within these relationships. Partnership is a political discourse of governance which has been employed by the New Labour government as part of their project to “modernise” English welfare services. As such, the term “partnership” shares characteristics with a number of other terms such as: “modernisation”, “transformation” etc (see 6 & Peck, 2004).

2.7 Chapter Summary

In studies of health and social care partnerships, assumptions pertaining to rationalist, technocratic models of policy making and implementation loom large. However, this thesis argues that there is much that can be drawn from the interpretive policy turn which can be useful in thinking about this way of working and its relative performance in practice. This thesis therefore considers partnership working not as a rationalist model which is invoked in order to bring about specific change, but as cultural performance of governance. This chapter has set out the theoretical and conceptual underpinnings of this research in a broad sense and these are built on further in illustrating the cultural performance perspective of partnership throughout the thesis. Key components within this formulation are the discursive forces of policy

and institutions and their symbolic and cultural value. These aspects have tended to be less visible (if not absent) in much of the extant literature, but as this thesis goes on to demonstrate, in considering the impact of partnerships it is crucial to think about the notion of cultural performance.

Chapter Three: “Four frames” of English health and social care partnerships

‘Academics have a role to play both in critically examining policy reform and in refining and developing frameworks which can offer conceptual clarity. Where there is a lack of precision in use of keys concepts and complexities in understanding accountability requirements, there is value in trying to identify the structures that underpin reform. Here, it is suggested that the case for NHS reform is premised on normative themes that gloss over such complexities’ (Morrell, 2006: p.382).

3.1 Introduction

Having set out the theoretical and conceptual underpinnings of this thesis in the previous chapter, this chapter sets out detail in relation to the policy context and the motivations driving this. Noting the critique by Morrell set out above, the account of policy offered in this thesis is not the standard historical (and usually chronological) account that is set out in the health and social care literature (for example, Means & Smith, 1998; Leathard, 2003; Glasby & Littlechild, 2004). This is a contribution to the existing knowledge base as it provides an interpretive analysis of this material. The theoretical lens of framing is used to illustrate the ways in which partnerships are seen as the logical or rational response to a set of different “problems” and each of which suggests a different potential end point or success factor for partnerships as a result.

It is important to note that this chapter does not suggest that any one frame should be afforded precedence over another. Some of the frames are afforded more physical space than others either due to their complexity or because they set out an account of policy which does not need to be repeated in the narratives of subsequent frames. It is argued that by unfolding the discourses of partnership this reveals a whole series of political positions and multiple realities relating to perceptions of the world of health and social care. As Fischer (2003: p. 145) suggests, ‘because the reality of a policy situation is generally too complex to be grasped through any particular account, policy controversies are inherently subject to multi-perspectival accounts’. The frames set out here provide an insight into the more prominent of these perspectives. Den Hartog and Verburg (1997) suggest that in the process of frame alignment, leaders communicate vision by, ‘placing the vision in a certain context, interpreting reality for listeners and giving meaning to events’ (p. 360) . It is intended that in setting out these frames an account of the sensemaking processes of these various positions is outlined. The frames examined in this chapter are:

- Structural
- Social challenges
- High performance
- Third way

After setting out the detail of these frames the chapter considers whether there are coherent “structures”, as Morrell would term it, underpinning this drive for partnership in health and social care.

3.2 Structural frame

'In essence the problem is that despite the best efforts of doctors, nurses and other staff the NHS is not sufficiently centred around the needs of individual patients. There are two major reasons why this is the case. First, decades of under-investment and second, because the NHS is a 1940s system operating in a 21st century world. The NHS is too much the product of the era in which it was born. In its buildings, its ways of working, its very culture, the NHS bears too many of the hallmarks of the 1940s. The rest of society has moved on' (Department of Health, 2000: p. 26).

As the quote from the *NHS Plan* illustrates, this frame proposes that partnership working is necessary in order to overcome the limitations of the ways in which health and social care organisations are structured, which is seen as a legacy of the establishment of the welfare state. The problem, therefore, is the organisational silos which form the basis of the welfare state and the solution is to introduce mechanisms to transcend these anachronistic structures. .

In 1942 William Beveridge's report on *Social insurance and allied services* (Cmnd 6404) was published and this is often credited as being the founding document of the post-war welfare state. The Beveridge report was written during the course of the Second World War and was published to an ecstatic reception. Despite being dense and lengthy it sold over 200,000 copies and received much attention overseas with the Treasury making a \$5000 profit from sales in the United States (Timmins, 2001). What this document set out was a future Britain where all citizens would be assured of "cradle to grave services" and not just those who could afford it.

This report is not simply considered a success because the country was ravaged by war and enduring hardship; this signalled unilateral access to welfare services. The War had been a great leveller in many ways and so this success also has to be considered against a backdrop of complex changes which were taking place in British society and had been set in train for some time before the onset of war (Timmins, 2001). Thus, from the outset the welfare state was more than simply a mechanism through which public services would be delivered, but a moral institution with enormous symbolic value. Indeed, Barbara Castle (former Secretary of State for Health and Social Services) employed the metaphor of a church to refer to the NHS; ‘intrinsically the National Health Services is a church. It is the nearest thing to the embodiment of the Good Samaritan that we have in any respect of our public policy’ (quoted in Klein, 2000: p. 86). Thus, if we take the discussion of policy symbolism set out in chapter two seriously, any proposed changes to these services could be seen as more than simply tinkering with structures, but as a more fundamental alteration in the values which are enshrined through these institutions.

The Beveridge report set out five major social problems which welfare services were designed to tackle - Want, Disease, Ignorance, Squalor and Idleness - often referred to as the ‘five giants’. Timmins (2001) records that the programme of reform established following this report consisted of social security, health, education, housing and a policy of full employment – each of which was constructed to combat one of Beveridge’s five giant evils. Jon Glasby has written extensively about the legacy of Beveridge’s impact on today’s welfare services and typifies the perspective of the structural frame. Glasby (2007) argues that although the language we use to discuss welfare services has changed somewhat in the intervening sixty years, much

of the diagnosis and the solutions set up to tackle these challenges can still be mapped across onto current services (See Table 3.1). Glasby argues that the advent of the welfare state saw a range of services established to deal with particular social problems and this pattern is still evident today.

Table 3.1: UK welfare services

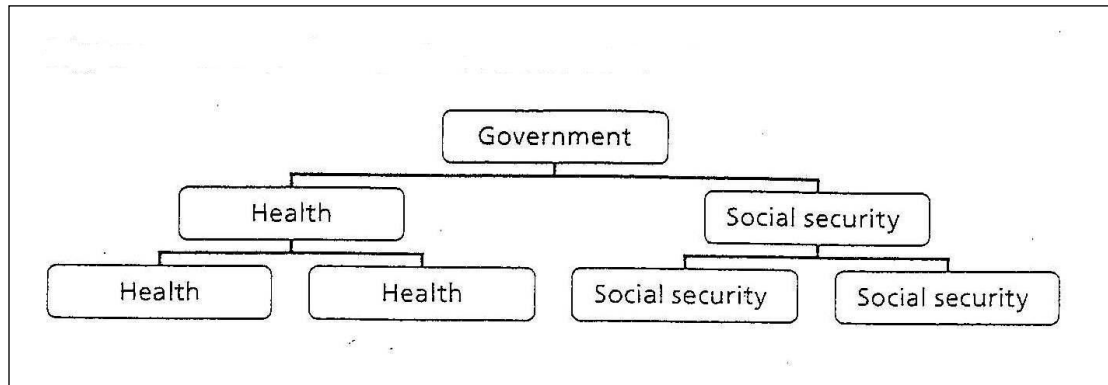
Beveridge's giants/social problems	Government response/service
Want	Social Security
Disease	NHS
Ignorance	Education
Squalor	Housing and regeneration
Idleness	Employment and leisure

(From Glasby, 2007: p. 13)

The structural perspective argues that despite the myriad of reforms which have taken place within the UK welfare state since its establishment, essentially what is still in place today are a range of top-down bureaucratic government departments who have as their core business a focus on one of these 'giants'. Before the establishment of the welfare state, health and social care services were delivered through various sectors and mechanisms (see commentators such as Payne, 2005; Means & Smith, 1998; McKay & Rowlingson, 1999; Ham, 2004; Baggott, 2004 for further detail) and the establishment of the welfare state represented a structural attempt to bring these services more directly under the control of central government in the form of a hierarchy mode of governance in the parlance of chapter three. Glasby (2007) sets out an illustration of these services and this is reproduced in Figure 3.1. In a number of

ways this is an overly simplistic and although appealing analysis of a complex policy context, one which is misleading in a number of respects.

Figure 3.1: Top-down, hierarchical services



(Glasby, 2007: p. 14)

The NHS was created in 1948 following the 1946 *NHS Act*, and inherited the pre-war legacy of a tripartite structure with clear divisions between local authority health and social services, hospital provision and general practice. This year also saw the introduction of the *National Assistance Act* which set out the responsibilities and powers of local authorities. From the outset therefore, there was a bifurcation in the management and administration associated with primary care/general practice on the one hand, and hospital services on the other. As a result, an administrative branch of the NHS was set up to handle general practice contracts, together with those of opticians, pharmacists and dentists. This led to the establishment of local executive councils. Hospitals were administered by hospital management committees, while community and public health services remained the responsibility of local authorities.

Following the *Seebohm Report* (1968), personal social services were unified under dedicated local authority directorates, but remained very much separate from the NHS structure and administration of health care provision. In arguing that the problems of joint working go back to the establishment of the welfare state, Glasby (2005a) notes that the Seebohm committee sought not only to unify previously disconnected social work functions, but also placed a strong emphasis on close working with other services such as housing, health care and education. Under the 1974 NHS reorganisation, local authorities lost control of their services for ambulances, public health and their medical officer of health and community and public health services were integrated into the NHS management structures along with hospitals (e.g. community nurses). Glasby highlights that social care services are absent from Beveridge's giants - an interesting omission given that Beveridge himself originally trained as a social worker. Glasby goes on to present the illustration set out in Figure 3.1 to show the welfare state response to the two giants of poverty and disease. It is more difficult to draw such an analogy with the area of social care as social services departments are the responsibility of Local Authorities and as such are not directly related to central government control. Recent changes in the division between adult and children's services add further complexity to the policy context and one which is not as easy to rationalise to the types of hierarchical relationships which are illustrated in Glasby's model.

Neither has the NHS ever been a monolithic and hierarchical structure as Glasby's analysis suggests. Since the establishment of the NHS, GPs have remained independent contractors which is not reflected in this model, nor are the range of independent agents who are increasingly being contracted with for the delivery of

health care services. Moreover, much has been written about the professional power of clinicians in maintaining a degree of autonomy within their roles and their reluctance to be managed in a top-down fashion from central government (Ham, 2004; Harrison & Pollitt, 1994). Mitzberg (1979) describes organisations such as the NHS as ‘professional bureaucracies’ and whilst this terminology might be conducive to thinking of the NHS as a hierarchy, these types of organisations are characterised by their strong horizontal linkages which impacts on the amount of vertical control which might be achieved. Thus, even if the NHS could be depicted in the manner which it is in Figure 3.1, the import of these horizontal linkages mean that these structures do not reveal the entire story in terms of the power held by clinical professionals.

In terms of function, Glasby argues that these hierarchical silos were established in order to combat Beveridge’s giants. Thus, when the National Health Service (NHS) is criticised as being a “sickness” service, rather than a health service (being primarily concerned with issues of disease and illness, rather than prevention), Glasby (2007) argues we should remember that it was originally conceived of in order to address the “giant” of disease. This is a profoundly deterministic perspective suggesting that because these organisations were set up to address a particular issue then this is all they will ever do (i.e. illness and not health). There is a strong sense of path dependence central to this argument. Originally developed by economists to explain technology adoption processes and industrial evolution, path dependence as a theory has now proliferated more widely into the field of social science. Essentially path dependence explains how the set of decisions available in any circumstance are limited by decisions made in the past, even if these circumstances may no longer be

relevant (Boas, 2007). Pierson (2004) suggests that path dependence might mean one of two things: that “history matters”; or that institutions are self-reinforcing. Clearly the first is a much broader definition than the second. Although in highlighting the legacy of Beveridge the structural frame demonstrates that history does matter, it is in the narrower definition where this theory is arguably most useful. Yet, as will be demonstrated below, although the structural frame hints at the first of these, it is much less explicit about the second.

The structural frame argues that the division experienced today and which has produced fundamental disparities between health and social care services was set firmly in place over sixty years ago (although, some services have at various times traversed between these boundaries). Consequently, social services are run by local authorities who come under an elected local government structure, whilst most health care provision is centrally directed by the Department of Health. Local authority social services are means-tested, whilst the NHS is based on central government financed provision and in principle should be free at the point of use. The English health and social care system of today is based on the assumption that it is possible to distinguish between people who are “sick” (and have health needs met free at the point of delivery by the NHS) and people who are merely “frail” or “disabled” (who are seen as having “social care” needs that fall under the remit of means-tested local authority services).

However, it is argued by commentators such as Glasby that the distinction between individuals who are “sick” and those who are “frail” does not often tend to be meaningful in practice. Particularly for individuals who require long-term care, it is

sometimes difficult to be definitive about whether the issue they are trying to get support with is one which is a “health” or “social care” need. Consequently, there are a number of accounts of vulnerable individuals and their families who have attempted to access services or support from the public sector and found that care either is subject to debates over who should pay, is uncoordinated, is of poor quality or in some cases is non-existent (for example, Glasby & Littlechild, 2004; Henwood, 2006).

Those arguing a structural case tend to point to the characteristics or tendencies which are typical of health and social services agencies as evidence of why they encounter difficulties in working together (an example is set out in Table 3.2). Yet, by being focused on the formal structures of these organisations, these arguments tend to pay much less attention to the less formal structures (in a traditional sense) which have built up around different professional groupings and are arguably of more importance in producing self-reinforcing institutions. As Stewart *et al* (2003: p. 336) argue, ‘the need to promote integrated working is produce of fragmented professional structure which has tended to encourage the development of coherent internal identities but has been less centred on the merits of cross-boundary activity across different professional groups’. One implication of the formalisation of services into “health” or “social care” is that professions and professional cultures have emerged, which are often presented as being as diametrically opposed in values and actions as the types of formalised structures set out in Table 3.2. It is argued here that a number of the high-profile debates which have recently occurred relating to structures of health and social care organisations have caused such outcry not because people are necessarily opposed to changes to organisational forms (of which there have been many over the

history of the welfare state), but because they are seen as an attack on the very values of professions (the example of Care Trusts and Hudson’s reaction (e.g. 2004b) to this is a case in point and discussed further below).

Table 3.2: Differences in characteristics of NHS and social services partners

NHS	Social services
Treatment	Care
National targets	Local needs
Must-dos	Local discretion
Universal services	Focus on vulnerable
Procedurally regimented and very top-down in style	Practical focus but has difficulty with strategy and planning

(adapted from Wistow & Waddington, 2006, p. 14)

In addition to being advocated by academics such as Glasby, the structural frame is strongly hinted at within health and social care policy documents of New Labour administrations. *Partnership in Action* proposed various ways of promoting more effective partnerships, basing these on a scathing critique of single agency ways of working (Department of Health, 1998b: p. 3):

‘All too often when people have complex needs spanning both health and social care good quality services are sacrificed for sterile arguments about boundaries. When this happens people, often the most vulnerable in our society... and those who care for them find themselves in the no man’s land between health and social services. This is not what people want or need. It places the needs of the organisation above the needs of the people they are there to serve. It is poor organisation, poor practice, poor use of taxpayers’ money – it is unacceptable’.

The problem identified here is very clearly the boundaries between health and social care agencies and many of the policy documents of this time used language which diagnosed the problem as being that ‘the NHS is a 1940s system operating in a 21st century world’ (Secretary of State for Health, 2000a: p. 10). This 1940s system does not sufficiently encourage the NHS to interact with other public sector agencies (or them with the NHS) and this is argued to be particularly problematic for the more vulnerable and frail within society. In stressing the 1940s aspect of these organisations, in governance terms this suggests a hierarchical mode and that the difficulties which vulnerable individuals encounter are due to these hierarchies.

The language in use here is deliberately emotive in calling for change and engaging health and social care professionals in what Leatherman and Sutherland (2004: p. 288-289) describe as the ‘most ambitious, comprehensive, systematic and intentionally funded effort to create predictable and sustainable capacity for improving quality of a nation’s health care system’. Indeed, the Labour government were clear that their legacy would be made on the ground of a modernisation programme across the entire welfare state (6 & Peck, 2004). When Labour came to power they diagnosed welfare services as being anachronistic, where older people and other disadvantaged groups were failing to be appropriately treated (if at all) and professionals were constantly battling against the “Berlin Wall” between health and social care. In terms of choice of metaphor, it would be difficult to select one that is more structural than the notion of the “Berlin Wall” which has such a significant place in recent geo-political history. The vision for the future was in services organised around the need of citizens, who would be empowered and staff members who would be able to do the sorts of jobs

which they came into the caring professions to do and not be encumbered by excessive, bureaucratic paperwork.

Suggesting that many of the difficulties encountered in health and social care services are related to the very structural foundations which they are built upon suggests a very particular sort of solution. If the problem is constructed as being related to the structures of these services, then seemingly the most obvious solution lies in changing these structures so that they are “fit for purpose” in today’s society. In conceptualising the problem as structural, there is a strong sense that somehow central government is responsible for the problems being experienced by health and social care professionals and service users. Central government’s responsibility in dealing with this is to design the most effective structures possible and have local agencies implement this (i.e. implicitly a rather “top-down” model of policy). This also suggests that there is a specific problem which central government has identified and is attempting to provide solutions to.

Despite the problem being diagnosed as structural, in the early years of the new Labour government the “ultimate” point of collaboration – integration – was not explicitly considered as an option. This is despite the positive reports about the state of the Northern Irish health and social care system which is integrated and has been since 1973 (although glowing reports have more recently been revised, see Heenan & Birrell, 2006 for detail). Social services chiefs were very vocal in expressing their opposition to integration, expressing concern that community services would be downgraded in favour of the dominant model of health. *Partnership in Action* stated that structural change in the form of integration was not the solution to the problem of

health and social care collaboration and given that this very same document diagnoses the problem as being due to the boundaries of health and social care this is a curious statement. However, in thinking about health and social care as institutions, rather than simply structures, it is perhaps clear why the government might try to resist ostracising social care professionals by attempting a structural change of this magnitude, which professionals seemed to suggest was a challenge to their very values and identity. However, a change of Secretary of State for Health and a frustration at a lack of progress brought a shift in this position and the introduction of care trusts.

Five years into their administration, central government policy documents continually hinted their frustration at slow progress and the need for more change, for example:

'We will keep the relationship between health and social services under review. Older people and other service users have the right to expect that local services are working as one care system not two. We will monitor how far the NHS Plan and these further reforms we are proposing take us towards that goal. If more radical change is needed we will introduce it' (Department of Health, 2002: p. 33)

Initially conceived with minimal detail, care trusts were basically an innovation in organisational structure (see Glasby & Peck, 2004); NHS Trusts were given an enlarged board on the assumption that elected members would require a greater presence within an organisation delivering social care services delegated from their local authority (and where the employment of local authority social care staff would be transferred to the NHS). By combining both NHS and local authority responsibilities under a single management and governance system it was suggested

that care trusts could: increase continuity of care; simplify administration; and, due to the formal status these organisations have in law, reduce some of the complexity of partnership working. In some senses, therefore, the type of organisation being produced through care trusts look more like Glasby's hierarchy of services. Although care trusts were initially introduced as being voluntary, there were suggestions that they should be forced on areas that were failing to collaborate "sufficiently". A marker of success or failure for central government therefore was measured by the degree to which health and social care services interacted, but not necessarily whether this led to any measurable impact.

The government had perhaps underestimated the amount of backlash which this innovation in structure would cause. Bob Hudson (e.g. 2004b) was the academic who was probably most vocally dissenting about care trusts, articulating the concerns of local authorities who felt that they would be subsumed by their more powerful partners. In formulating these arguments, local authorities seem to be expressing a concern that such a partnership was essentially driven by the same sorts of motivations found in constructions of resource dependency. Whilst publically speaking about the fear that the NHS would inevitably draw up local authority resources for use in the delivery of health care services, there was also a sense that such an arrangement would lead to the NHS having power over social care services which could potentially lead to an erosion of the values of these professionals.

Although when care trusts were initially announced it was suggested that these would eventually be introduced in every local health and social care community, the government later backed down from this position acknowledging that locally

appropriate solutions to the issue of health and social care collaboration were more important than a single model. At the time of writing, just ten areas in England have opted to adopt this structural innovation (five of which are based in the provision of mental health services). Often where this model has been implemented it has been to protect locally based services which were perceived to be coming under the threat of a possible reorganisation (Dickinson *et al.*, 2007). In this sense it could be argued the “structural solution” has failed given that it has not increased the amount that health and social care services interact and this has been for reasons which are arguably unrelated to formal organisational structures.

In 2003, the Green Paper *Every Child Matters* (HM Treasury, 2003) was published alongside the Government’s response to Lord Laming’s (2003) report into the death of Victoria Climbié, which was suggested to be partly due to a failure in communication between public agencies. The 2004 *Children Act* is the legislative incarnation of this Green Paper which encouraged integrated planning, commissioning and delivery of services, as well as improved multi-disciplinary working, removal of duplication, increased accountability and improved coordination of individual and joint inspections in local authorities. Children’s trusts were the proposed mechanism through which all this would be achieved. Children’s trusts were not a new concept and were being piloted in some areas prior to the Laming report, but they gained increased interest and salience following this publication.

Children’s trusts differ from care trusts in that they were intended to be “virtual” as opposed to “real” or formal structures in a legal sense. Moreover, education was to take the lead in this relationship as opposed to health – which, as outlined above, had

attracted criticism in terms of care trusts. What this period also started to see was more of a significant split in terms of adults and children's services, leading to reports of considerable difficulties in terms of transitions between these services and blurring of responsibilities over family-based services. In other words, although new structures had been formed to try and further integrate health and social care services, children and adults tended to have different requirements and this therefore led to different partnership arrangements forming a schism between adult and children's services.

In some ways these divisions demonstrate the inevitability of boundaries. Welfare services are generally thought too large to be able to be governed 'in the round' (6 *et al.*, 1999), but in assigning responsibility for particular aspects of services this inevitably produces boundaries. A consequence of this is that structural boundaries will always be with us. Walter Leutz (1999; 2005), illustrates this issue in what he terms his "laws" of integration (Box 3.1). Aside from the fact that this illustrates the types of prescriptive pronouncements of "must-dos" that run through the literature on health and social care partnerships, what he does draw attention to is the number of services which it is possible to integrate at any one time. "Laws" one, three and eight all essentially state that it is only possible to formally integrate some services.

Box 3.1: Leutz's laws of integration

1. You can integrate some of the services for all of the people, or all of the services for some of the people, but you can't integrate all the services for all the people.
2. Integration costs before it pays.
3. Your integration is my fragmentation.
4. You can't integrate a square peg and a round hole.
5. The one who integrates calls the tune.
6. All integration is local.
7. Keep it simple, stupid.
8. Don't try to integrate everything.
9. Integration isn't built in a day.

(Leutz, 1999; 2005)

This section has outlined a structural frame which proposes that health and social care partnerships are necessary because of the ways in which the welfare state was established in the era of “big government” with its associated organisational silos. As this account demonstrates; over time these structures have shifted and changed. Most significantly in 1974 under the NHS reorganisation, and again with the more recent introduction of care trusts and children’s trusts. The problem as described by this frame is that the demarcation between individuals who are sick (and require health care services) and those who are frail or disabled (and require local authority social services) is not always meaningful in practice. However, in demarcating the problem as structural this offers the prospect of a “solution”. Such a structural solution may inevitably appeal to time-short politicians looking to demonstrate some form of impact. Yet, attempts at changing these structures have not been successful in

promoting more interaction between health and social care organisations. Indeed, this frame also overlooks that boundaries are essential in organisational governance; new boundaries simply create new problems.

Key proponents of the structural frame have a tendency to represent this as a profoundly deterministic sequence of events and thus may be characterised by path dependency theory. However, in being focused on the formal structures of organisations the structural frame underplays the significance of the “less formal” institutions which have been produced as a result of the formal structures. The establishment of an institution which address “health” issues and another that deals with “social care” may be associated with producing particular and separate professional models and values. Over time there have been a series of conflicts when one has been perceived to encroach on the boundaries of the other. Thus, these institutions have become self-reinforcing and this goes some way to explaining why there have been particularly strong reactions at various points over the past sixty years when efforts have been directed into changing these institutions (e.g. introducing care trusts).

3.3 Social challenges frame

‘This Government inherited health and social care services facing profound challenges. Years of under-investment, widening inequalities, soaring waiting lists, critical staff shortages, inflexible and unresponsive services – all needed tackling... And new challenges are emerging. A nation getting older – and sadly more obese. Fifteen million people with long-term needs...needing better prevention and earlier care. The poorest areas too often with the poorest health

and the poorest care...people wanting a different approach to services, looking for real choices, more local care, taking greater control over their health, supported to remain independent wherever possible' (Secretary of State for Health, 2006: p. 3).

The social challenges frame suggests that the problem is the existence of “wicked issues” which are endemic in society. According to this frame a whole range of issues (e.g. demographic changes, new technological advances, expectations of the population and endemic social issues such as drug abuse, crime, health inequalities) all pose significant challenges to society and are becoming ever more prevalent. The solution to this problem is that health and social care organisations must work together (and with others) to form collaborative efforts to tackle these issues. It is important to note that these collaborative efforts should be led by public sector organisations due to the types of moral values which they enshrine. These values not only ensure that the most appropriate solutions are constructed, but that in being led by the public sector, symbolically this should act to contain civic anxieties in relation to these pernicious social issues (returning to the traditional Weberian values of public bureaucracies, see Du Gay, 2000; 2005).

The term “wicked issue” is usually attributed to Rittel and Webber (1973) and refers to those intractable social problems which no one individual agency, or indeed sector, would be able to address by acting independently. It is proposed that wicked issues are not simply complex in terms of our ability to understand the range of processes at play, but also tend to be deep-seated and temporally enduring issues which have not been effectively addressed (or even understood) by individual agencies in isolation. In the sphere of health and social care, such complex problems include hospital

discharge planning, safeguarding children, substance misuse, teenage pregnancy, long-term unemployment and health inequalities: all of which it is proposed require a collaborative approach by multiple actors if they are to be effectively understood and resolved. These are the types of issues which cause societies civic anxieties and other collective sentiments, which may be both conscious and unconscious (Obholzer & Roberts, 1994).

As set out in chapter one, the neoliberal critique of bureaucracies is that they are outmoded in the sense that they are portrayed as being inefficient and unresponsive. Not only are such arrangements large and unwieldy, they also only provide services for the average citizen - arguably not what individuals specifically want or need. Yet, the original Weberian meaning of bureaucracy is that it is a particular and unique form of moral institution (Du Gay, 2000; 2005). Additional value comes from bureaucracies in the management of social anxieties and collective sentiments through the projections of its citizens (Hoggett, 2006). The tenets of traditional Weberian bureaucracy (e.g. Weber, 1947) suggest that there are a range of complex problems which contemporary society faces which cannot be overcome by one agency operating independently. Therefore, not only is partnership working necessary, but it is crucial that this is led by public sector bodies for the moral values which these institutions embody with their ability to contain civic anxieties in an ever more pluralist and diverse society.

The plans for a welfare state for Britain in the 1940s were not simply so warmly received as they promised to bring “cradle to grave” services to the population. This was a symbolic gesture of the way in which the government would act in order to

support and protect the entire population (not just those who could afford it). In doing this, the Labour government of the time saw a strong role for the public sector in the lives of its citizens, one which later Conservative governments would criticise as encroaching on the rights of individuals. Particularly under the leadership of Margaret Thatcher, it was suggested that the government should have less interference in the lives of individuals and that this would enable people to take more responsibility for their own decisions and destiny rather than relying on a “nanny state”. This is perhaps most famously illustrated through the following quote:

‘I think we’ve been through a period where too many people have been given to understand that if they have a problem, it’s the government’s job to cope with it. “I have a problem, I’ll get a grant”. “I’m homeless, the government must house me”. They’re casting their problem on society. And, you know, there is no such thing as society. There are individual men and women, and there are families. And no government can do anything except through people, and people must look to themselves first. It’s our duty to look after ourselves and then, also to look after our neighbour’ (Thatcher, 1987).

However, in opposition the Labour party extensively critiqued this position, arguing that many of the wicked issues which individuals in society face (like homelessness) are not simply the result of the actions of these individuals themselves. So, homeless individuals cannot simply be blamed for being homeless, there are social structures at work which cause inequalities that impact on specific tranches of society and make it more likely that these individuals will experience hardship. Thus, they argued that there is a legitimate role for the government in leading coalitions to tackle wicked issues. Because government can be trusted to act in the best interests of the wider population this should quell the civic anxieties of individuals in respect to the

existence of these wicked issues. Since 1997 there have been a plethora of both partnerships to address wicked issues and these have either focused on places or on people.

Between 1997 and the early years of the twenty-first century the government introduced a plethora of area-based “initiatives” (e.g. Healthy Living Centres, Sure Start, New Deal for Communities, Education Action Zones, Children’s Fund projects etc) which tend to have broadly similar aims around improving health care (or latterly well-being) and reducing inequalities. Often these locality-based initiatives would co-exist within socio-economically deprived areas. This case of “initiativitis” contributed to a range of difficulties associated with the evaluation of these partnerships, given that many had broadly similar aims and were located within the same places. Health Action Zones (HAZs) are a prominent example of these types of area-based initiatives. Evidence from these initiatives is set out in the following chapter, a brief introduction is provided here as context to this discussion.

The HAZ initiative was launched in 1997, pledging to set up 11 (which was later extended to 26) seven-year pilot projects. These were intended to ‘explore mechanisms for breaking through current organisational boundaries to tackle inequalities and deliver better services’ (Department of Health, 1997: p. 1). HAZs were established in areas of pronounced deprivation with poor levels of health and initially developed targets to tackle entrenched inequalities through partnership working between hospitals, GPs, local authorities, voluntary bodies and local businesses working together on regeneration schemes to improve local health (Barnes *et al.*, 2005). However, HAZs were not simply about improving health outcomes and

reducing health inequalities but also about acting as trailblazers in terms of the ways in which areas could work together in partnerships. Beyond these broad aims, Powell and Moon (2001) argue that because specific criteria were never outlined for the selection of HAZs it is difficult to understand the rationale behind this initiative. Individual HAZs had very different themes and progressed in rather different ways. Because of this variation it is difficult to be definitive in terms of judgements about their success. The Health Development Agency (2004: p. 2) concludes, ‘the HAZs felt that their direct impact on health inequalities was minimal – because of the short timeframes of the HAZ initiative and limited resources – although specific projects had changed individuals’ lives’.

This sort of new area-based initiative therefore provided a distinctive strand to New Labour policy due to criticisms that earlier efforts had tended to be based on people, and not place, poverty (see Powell & Moon, 2001 for an overview of this debate). People-based partnerships have a much longer history, with initiatives around specific service user groups. Starting in the late 1970s, mental health teams were encouraged in an attempt to overcome factors which had hindered collaboration between health and social care agencies (Department of Health and Social Security, 1978). Although these teams initially tended to comprise predominantly of GPs and community psychiatric nurses, under the 1990 *NHS and Community Care Act* social workers were also required in order to assess social care needs. These teams have been increasingly extended to a range of other professions such as psychologists, psychiatrists, counsellors, occupational therapists and art therapists (Kingdon, 1992).

Operating within a rationalist model of policy, it could be assumed that these wicked issues were identified by government and mechanisms were accordingly set in place in order to address them. Such an approach clearly separates out the problem from the solution. Yet an interpretive perspective suggests that this issue is not as clear-cut as would first appear; the problem does not necessarily exist in a discrete way in itself but is in part created by the government as a way of legitimating particular courses of action (Freeman, 2007). Issues such as changing demographic profiles, new technologies and changing working practices are not necessarily innately pernicious social challenges which only a government response might address. Yet, the Labour government has gone to great pains to describe these as big issues which will challenge the fundamentals of our welfare services. In legitimating *why* the process of modernisation needs to take place across welfare services, government documents have frequently intimated that health and social care organisations need to work together in order to be able to face these vast challenges. In this sense, the government has constructed a crisis around particular issues as a way of legitimating a range of organisational (and more recently funding) changes under the rubric of responding to these challenges and at the same time seeking to reassure the wider population that they need not feel anxious as the government is responding to these issues.

Safeguarding is another area where partnership working is seen as being crucial by government. A key concern of the types of mental health teams described above has become the issue of safety, arguably usually of the wider public rather than service users. A number of high profile cases of homicide by mental health service users have led to these teams being directed to pay much more attention to the protection of

the general public, often following official reviews of these events (for example, the death of Tina Stevenson and her unborn twins in Hull in 2005 and Ivy Torrie who was killed in 2003 by her son). Yet homicides by the mentally ill go back centuries and the level committed has remained relatively constant at around fifty per year since the 1950s, even though homicides overall have roughly tripled over the same period (BBC, 2009). Official reviews have often played a role in explaining why health and social care partnerships are necessary, usually suggesting that without such mechanisms individuals or the public will not be safe (Kewell & Beck, 2008). The issue of public safety was also prominent in debates relating to the *Mental Health Bill* over initial plans to detain individuals with severe personality disorders even if they had not committed a crime. The problem was framed as these dangerous individuals, so clearly the solution was to detain these - although this met extreme criticisms from bodies such as the Mental Health Alliance. Although individuals with mental health problems committing murders is clearly a wicked issue and may be susceptible to some reduction, it is arguable that these might not ever be made extinct even by going to such draconian lengths as removing any form of individual rights from such people.

Children's services frequently received attention for concerns over safeguarding. In 1988 the *Report of the Inquiry into Child Abuse in Cleveland* (Butler Sloss, 1988) was published, one of a number of reports and investigations into child abuse over the previous twenty years. This was followed in 1989 by the *Children Act* which led to policy guidance from the Department of Health (1991) around how the various groups involved in the care of children could more effectively work together. Joint policies and procedures were also to be established in the working relationships between social services departments, the police, doctors, community health workers and

others. Area Child Protection Committees were set up to encourage liaison of professionals and agencies involved in child protection work.

Cases of child abuse have been prominent drivers for governmental pronouncements that what is required is more joint-working between government (and indeed, non-governmental) bodies. Children's trusts were formally introduced following the Laming report which investigated the circumstances culminating in the death of Victoria Climbié. As the (then) Health Secretary explained:

'[T]here were failures at every level and by every organisation which came into contact with Victoria Climbié. Victoria needed services that worked together. Instead the [inquiry] report says there was confusion and conflict. The only sure-fire way to breakdown the barriers between these services is to break down these barriers altogether' (BBC, 2003).

Children's trusts have brought in changes to structures and processes of children's services around the country, but have often changed very few practices on the ground or made a difference to the lives of children in these areas (Audit Commission, 2008). Nowhere has this been more starkly illustrated than in Haringey, where Victoria Climbié lived and where Baby P, a 17-month old boy, died August 2007. Baby P endured months of abuse and had seen been approximately 60 times by health or social workers over his short life (Glendinning & Jones, 2008). There are some parallels between the detail of the Victoria Climbié and Baby P cases confirmed through Lord Laming's (2009) report on child protection. This report stated that insufficient progress has been made on the initial recommendations which led to the establishment of children's trusts. Children's trusts were presented as being the "natural" solution to the issue of safeguarding by addressing fragmentations in

children's services. Yet, children's trusts are not actually legally responsible for safeguarding which raises a series of questions about whether they really were a coherent solution to the issue of safeguarding. Another perspective could be to suggest that children's trusts were a "solution" *in search of a* "problem". After all, children's trusts were being piloted prior to their high profile announcement *in Every Child Matters* but were largely not seen as a necessary or popular arrangement. With the high profile death of Victoria Climbié and the surrounding publicity this provided a clear problem that children's trusts could provide the solution to.

Central government realised that it needed to be seen to be putting effort into handling the anxieties of the public in terms of the issues of safeguarding children. The response was to announce that all local areas should have a children's trust. However, given that there was little guidance over what children's trusts should actually do, or how they could better co-ordinate these types of activities, perhaps a question could be asked as to whether these entities were the ideal (or only solution) to keeping children safe, healthy and happy. In his initial report, Laming (2003: para 1.27) asserts, 'the single most important change in the future must be the drawing of a clear line of accountability, from top to bottom, without doubt or ambiguity who is responsible at every level for the well-being of vulnerable children'. In practice children's trusts do not seem to have achieved this - except perhaps in one sense.

Following enquiries into the death of Baby P, in a rather unusual move Ed Balls (Secretary of State for Children, Schools and Families) used special powers to call for the removal of Haringey's Director of Children's Services, Sharon Shoemith. Balls (2008) stated:

'The whole nation has been shocked and moved by the tragic and horrific death of Baby P. All of us find it impossible to comprehend how adults could commit such terrible acts of evil against this little boy. And the public is angry that nobody stepped in to prevent this tragedy from happening. I want to say very clearly at the outset: social workers, police officers, GPs, health professionals, all the people who work to keep children safe, do a very difficult job, often in really challenging circumstances – all around the country and in particular in Haringey. They make difficult judgments every day that help to keep children safe – and many of them are unsung heroes. But they must also be accountable for their decisions'.

This is clearly a strong symbolic statement that accountability for the death of Baby P was being executed, even though there were large debates over whether Shoemith could truly have prevented the death of Baby P given that there were much wider organisational and workforce pressures in operation.

Central government has been vocal about the fact that responsibility for safeguarding of children should lie with public sector bodies and a range of reforms have been brought in under the notion of partnership through children's trusts. These have not, however, proved widely successful in their impacts on the safeguarding of children but do have immense symbolic and rhetorical value in terms of the government being seen as handling (or not) civic anxieties in relation to this pernicious social challenge. This is illustrative of the types of responses which have also been formed in relation to other wicked issues, where the construction of a particular issue is intimately tied to the proposed solution and the legitimacy to act in a particular way.

3.4 High performance frame

'Well-designed targets make for consistency, accountability, equity and flexibility to meet local needs. Local partnerships need to be the main managers of performance. The resulting information should be available in a transparent, accessible way with much greater provision of up-to-date data at the local level. Government needs to ensure that multiple requests for the same information are avoided with more systematic use of the information that is collected' (Department for Communities and Local Government, 2007: pp. 7-8).

In the construction of the high performance frame, the influence of New Public Management (NPM) is significant. The problem is the existence of multiple statutory and non-statutory organisations involved in, or impacting upon, the delivery of welfare services. The solution is to employ managerial techniques pioneered in the commercial sector in forming partnerships between these various organisations and performance managing their activities.

NPM is broadly defined as a management paradigm which can be identified internationally from the late 1970s onwards, although it varies from country to country in its implementation. Commentators such as Ferlie *et al* (1996) suggest that it is not *one* paradigm, but a cluster of several. Essentially NPM is founded on a critique of bureaucracy as the organising principle of public administration (Dunleavy, 1991). The NPM view of bureaucracy is that it is inflexible and overly hierarchical. The top-down decision-making processes associated with this model were suggested to be increasingly distant from the expectations of citizens. NPM theorists drew on the commercial sector for lessons, arguing that because of the large scale international competition private sector organisations had been exposed to from

the 1980s onwards, those successful had become increasingly efficient, whilst also offering consumers products which they wanted. The commercial sector had undergone radical change but it was argued that the public sector remained 'rigid and bureaucratic, expensive, and inefficient' (Pierre & Peters, 2000: p. 5).

The principles of NPM are, in general, characterised as an approach which: emphasises output controls; disaggregates traditional bureaucratic organisations and decentralises management authority; introduces market and quasi-market mechanisms; and, strives for customer-oriented services. This way of working puts much more emphasis on the importance of performance managing outcomes, determining what it is that service users want from their health and social care services and delivering this through flatter and less hierarchical structures. As Hood (1991) describes, these reforms are characterised by decentralisation of power to local levels, with managers increasingly taking responsibility for budgets and being allowed greater flexibilities in terms of their actions - but simultaneously bearing more responsibility for the outputs and outcomes of that particular unit. Although it is never described as such by the authors, one text that illustrates facets of an NPM approach is Osborne and Gaebler's (1993) *Reinventing Government*. One of this text's key principles is that governments should '*steer, not row*'. The implication here is that if governments concentrate more on *what* should be delivered (and performance managing this), instead of *how* it should be delivered, they will be more effective.

NPM emerged as a reaction to Public Administration and a perception that the days of big bureaucracy had "failed to deliver". The solution was to disaggregate these large

governments even further which has produced a public sector that is even more “congested” than before with a range of different public, private and community sector organisations involved in the delivery of services. Interest in NPM first came about at a time when the country was experiencing significant economic problems (e.g. high rates of unemployment and inflation) in addition to long-standing criticisms over the quality of public services and their efficiency. By the late 1980s it had become apparent that the Conservative government was under a range of pressures in terms of the NHS and that Margaret Thatcher’s interest in reform would inevitably turn its attention to the health service. There were a number of challenges facing the NHS such as: a need to curb the growth in public expenditure; large variations in performance in different areas; lack of information and choice for consumers; accusations of insufficient management; long waiting lists; staff shortages; and difficulties in admitting emergency cases which seemed stubbornly difficult to resolve (Dixon, 1998).

Following a death of a child in Birmingham in 1987 when a life-saving operation was cancelled due to a lack of intensive care nurses, Thatcher announced a review of the NHS. This review resulted in the white paper *Working for Patients* (Department of Health, 1989) which aimed to improve value for money, reward efficient and higher quality providers, and encourage greater responsiveness of services to patients. The main proposals set out in *Working for Patients* were concerned with reforming the organisation of the NHS, including:

- Separation of purchaser and provider functions;

- Hospital, mental health providers and community trusts could apply for self-governing status as NHS trusts; and
- GP practices could apply to become ‘GP fundholders’, where they took on a purchasing budget for pharmaceuticals, outpatient care, community health services, and some elective hospital procedures.

These reforms had a significant impact not only on the way in which NHS services would be provided, but also inevitably the manner in which health and social care services interacted with one another. Although central government was promoting joint action between health and local authorities, the Health Education Authority, local education authorities and voluntary organisations through health alliances (Secretary of State for Health, 1992), the introduction of the internal market suggested a more fragmented health service which could potentially pose challenges in terms of collaboration within the NHS itself.

The logic behind the Conservative government’s reforms was that, as purchasers and providers would be separate organisations, money would no longer flow automatically from purchaser to provider and providers would be required to compete for business. The term ‘internal market’ became widely used to refer to this reform process, broadly suggesting that the buying and selling of services would happen within the NHS as separate activities. However, as Paton (1995) illustrates, the purchaser-provider split introduced a number of perverse behaviours and incentives which were not initially anticipated. The most significant of these were the additional transaction costs introduced through a mushrooming bureaucracy associated with the separation of purchasers and providers.

Although the Labour government stated its commitment to dismantling the internal market when it first reached office, in practice health and social care organisations have in recent years seen an exponential growth in the number of statutory organisations involved in the delivery of health care (Primary Care Trusts, Acute Trusts, Foundation Trusts, Mental Health Trusts, Ambulance Trusts etc) but also non-statutory bodies (independent GP practices, independent sector treatment centres, social enterprises and other third sector bodies involved in service delivery). Local authorities have an even greater pedigree in this respect since the introduction of compulsory competitive tendering of goods and services in the 1980s. Disaggregated service delivery organisations are intended to be focused on particular tasks with the power and autonomy to govern their own activities are headed by strong leaders who may be held accountable for their specific outcomes. However, one consequence of this is that such a system is difficult to steer in an overall strategic sense. Partnerships are therefore necessary in order to be able to performance manage services within local areas against defined priorities.

PCTs and local authorities have a duty to undertake joint strategic needs assessments within their local areas and the results of which inform the Local Area Agreement (LAA). In each area named public sector agencies also have a duty to co-operate with the local authority to agree LAA targets and then work towards the delivery of these targets. LAAs are the framework through which national standards and priorities are brought together with the local priorities that have been developed by the local authority and its partners. LAAs are overseen by Local Strategic Partnerships (LSPs). The local authority is the lead partner in the LSP and the statutory ‘responsible body’

for the LAA. Ultimately then, the purpose of these mechanisms is to performance manage local bodies against an agreed set of national and locally applicable targets but in a way that promotes collective high performance rather than necessarily individual high performance. As Provan and Milward (1995) demonstrate in a US context, even if individual network organisations provide excellent services on their own, the overall network performance might be low. Therefore, networks require some form of co-ordinating mechanism to assure the entire level of performance.

These mechanisms also highlight the strong theme of area based initiatives which runs throughout much of new Labour's policy, and which suggests that focusing partnerships around specific places can produce collective synergy:

'LAAs are crucial to ensuring priorities are being met. Priorities will need to vary from place to place. Targets can be set at the most appropriate level – from neighbourhood level to county-wide. They can also be set at sub-regional level, through Multi Area Agreements (MAAs). These may be particularly appropriate to deliver sustainable economic development and other outcomes best delivered at sub-regional level. In LAAs and MAAs alike, the agreements will focus energies and resources for local authorities and their partners on working towards delivery of their shared priorities' (Department for Communities and Local Government, 2007: p. 16).

Although NPM was thought to be a way of driving improvement and efficiency through public services, the resulting disaggregation had created difficulties in setting strategy at a meta-level and being able to steer the entire local system. Partnerships such as LAAs and LSPs are therefore crucial in holding individual service organisations to account for their specific responsibilities, and also holding them jointly to account for the work they do together in delivering public service outcomes.

These partnerships are about much more than just these individual responsibilities. Their power comes in promoting notions of collective high performance.

3.5 Third Way frame

‘[T]hird way’ refers to a framework of thinking and policy-making that seeks to adapt social democracy to a world which has changed fundamentally over the past two to three decades. It is a third way in the sense that it is an attempt to transcend both old-style social democracy and neoliberalism’ (Giddens, 1998: p. 26)

Just like the concept of partnership, the notion of a ‘third way’ is not new, with Giddens charting its use back to the 1920s although at this time it was predominantly used by right-wing groups rather than social democrats and socialists. By the time that the 1990s had arrived and the “iron curtain” had fallen from the socialist states of Eastern Europe, social democracy across Europe ‘fell into a state of depression’ (Cuperus & Kandel, 1998: p. 13). The socialist project was seen to have failed and in many countries across Europe and North America, conservative, neoliberalist governments had been in situ for some time. Yet, Giddens argues that the neoliberalist programme was inherently contradictory; striving for market fundamentalism and being inherently Conservative at the same time (p. 15). The third-way or ‘new social democracy’ or ‘neue mitte’ (Clasen, 2002: p. 67) was seen as a way of renewing social democratic values in a world where ‘there are no alternatives to capitalism’ (Giddens, 1998: p. 24). The third way therefore, was seen as a way of consolidating democracy for a new world as the quote at the start of this

section illustrates. However, the third way also served as an ideological tool which renewed confidence in a Labour party which had been out of power for some time.

The third way professes to embrace a mix of market and interventionist philosophies, stressing technological development, education and competitive mechanisms in order to pursue economic progress and governmental objectives. Like NPM, this philosophy has been observed in a number of countries around the world (most notably in the US and Australia), but in terms of the British context Anthony Giddens (1998) has probably been the Third Way's most central proponent and one who has had a significant impact on both Tony Blair and Gordon Brown (see for example, Blair, 1998). It is arguably the influence of third way-type politics that introduced the 'New' into New Labour. Electoral setbacks had led the Labour party to seek alternatives to 'old-style' labour values and instead seek to modernise the party into one which was seen as fit to lead within the 'new globalised world' (Giddens, 1998: p. 5).

Giddens argues that major difficulty with neoliberalism is that it fails to take account of the negative implications that market fundamentalism ultimately produces. Partnership working appears as a fundamental part of the third way within a discourse of networked governance (Rhodes, 1997; Jessop, 2000; Stoker, 2000) which is characterised by a loosening of statist, bureaucratic welfare delivery and the simultaneous recognition of the failure of markets to provide an appropriate mode of welfare production and delivery. 'Government can act in partnership with agencies in civil society to foster community renewal and development. The economic basis of such partnership is what I shall call the new mixed economy. That economy can be

effective only if existing welfare institutions are thoroughly modernised' (Giddens, 1998: p. 69). This "modern" mode of governance reflects the reality of a complex welfare system which is delivered by a range of providers and relies on horizontal, self-governing networks (Rhodes, 2000). In this mode, central government acts as an enabler, rather than coercing actors or organisations to behave in particular ways (Stoker, 2000). 'State and civil society should act in partnership, each to facilitate, but also to act as a control upon the other' (Giddens, 1998: p. 79). Thus, the third way envisages quite a different mode for the state than those which have gone before.

In contrast to previous administrations, the Blair government that was elected in 1997 was clear at the outset that it wished to pursue a 'third way' in terms of public policy. This approach lay between the 'Old Labour command and control' and the internal market approach of the Conservatives (Ham, 2004). The structural upheaval and costs of the Tory reforms had been substantial and this had implications for the start of the Labour term. Given the massive changes which had taken place, the Conservative reforms would be difficult to ignore and it was clear that Labour were not able to start with a blank sheet of paper (Paton, 1999). Labour had been hostile to the 1989/91 NHS Reforms, but Timmins (2001) reports that, even then leader Neil Kinnock has since stated, had Labour won the 1992 general election they would not have reversed the purchaser/provider split. Although Labour was critical of what it saw as neoliberal Conservative reforms, they were suggesting that they would not retreat to the large bureaucracies of "old" Labour.

The welfare state in the period from 1997 onwards on might be characterised as being – at least according to central government rhetoric - networked governance.

Rummery (2002: p. 230) concurs stating:

‘While the British welfare state probably never exhibited ‘pure’ forms of either bureaucratic or marketised methods of governing, and is probably also unlikely to ever exhibit ‘pure’ forms of networked governance, in theory partnerships are to networked governance what contracts are to markets and command-and-control mechanisms are to bureaucracies: an essential element of that particular method of government’

The overarching health policy of the new government was set out in a White Paper in late 1997 (Secretary of State for Health, 1997). The third of the six principles underpinning the new NHS was outlined as *partnership* (p. 11). Organisational barriers were to be broken down and stronger links forged with local authorities so that the needs of patients and service users would be placed at the centre of the care process. The concept of citizens, rather than passive recipients of services, firmly entered central government lexicon, arguing that individuals should have more say in their care and this is most explicitly exemplified through the introduction of direct payments in social care. NHS trusts were provided with a new statutory duty to work in partnership with other NHS organisations and local authorities to shape services and develop health improvement programmes (HImPs).

Given that much of New Labour’s conceptualisation of the third way is based on that of Giddens, it seems a little odd that this interpretation of partnership is one which is primarily inter-organisational, rather than one between the citizen and the state. The third way is fundamentally concerned with the modernisation of the welfare state and

‘in what ways, capitalism should be governed and regulated’ (Giddens, 1998: p. 44) and this concern extends beyond simply thinking about nation states to the issue of globalization. ‘Global problems respond to local initiatives but they also demand global solutions. We can’t leave such problems to the erratic swirl of global markets and relatively powerless international bodies if we are to achieve a world that mixes stability, equity and prosperity’ (Giddens, 1998: p. 153). Yet the incarnation of the third way in health and social care policy seems to be more fundamentally concerned with the types of horizontal linkages between service delivery agents, than links to citizens and to supra-national bodies.

What is important in setting out the need for partnership is the existence of a particular political ideology which would allow the Labour party to differentiate itself from the Labour party of old. Whilst “Old Labour” was concerned with taxation and big governments, “New Labour” presents itself as a modernised party fronted by the young and charismatic Tony Blair. The third way therefore was seen as a way of renewing confidence in a “New” Labour party and of correcting the inherent contradictions of neoliberal policies. An important component of this modernisation is the renegotiation of the settlement between the citizen and the state and the role of networked governance within a new mixed economy.

Thus, what is central to establishing the problem and solution within this frame is that the New Labour government placed partnership working at the central core of its public policy not simply because it recognised the short comings which had befallen welfare services and their service users, but instead (or additionally) because partnership was a key component in the ideology which underpinned and

characterised much of their initial period in office (despite the fact that commentators such as Norris, 2001 argue that this ideology is incredibly difficult to pin down and may be described as lacking in substance). In other words, health and social care partnerships exist because partnership is a crucial component of the third way political ideology which was crucial to the rejuvenation of the Labour party. Therefore partnership is seen as a legitimate way in which to improve (modernise) public services. Moreover, the English incarnation of the Third Way might be characterised as an attempt to form networked governance (NPG in Osborne's terms).

3.6 What do these frames tell us?

At one level quality services and service user outcome are central drivers to all of these frames, although in a rather abstract sense. On closer inspection, each of the frames identified here constructs the "problem" which partnerships are responding to in a different way. Frame analysis suggests we cannot say that any one of the frames identified is "correct"; different stakeholders will perceive and value these frames in different ways. There is also an issue of temporality in terms of these frames. The structural frame is based on an analysis that starts with Beveridge and develops over time, whilst the other frames are often more concerned with, or pronounced within, particular time periods. What these frames demonstrate are the range of different ways there are in the policy and academic literatures of talking about why it is that partnership is necessary in health and social care and what it should therefore achieve in practice.

Just as none of these frames are “correct”, neither will individuals necessarily just subscribe to the arguments set out in one of these frames. Yanow (2000a) proposes that multiple frames might be held by actors within a system. Different stakeholders may believe a health and social care partnership is driven by one (or more frames), whilst other stakeholders may hold contrary perspectives. Conflict comes into play when these understandings come into contact with one another and form contradictions. What this exercise demonstrates is the complexity of the concept of health and social care partnership and highlights the diverse range of values which might simultaneously occupy this arena (summarised in Table 3.3).

Table 3.3: Four frames of health and social care partnerships

Frame	Why are health and social care partnerships necessary?
<i>Structural</i>	Legacy of Beveridge. Due to the way the welfare state was established, according to notions of big hierarchical government therefore health and social care organisations exist as silos. Partnerships must exist to overcome these structural barriers
<i>Social Challenges</i>	The issues facing public services are primarily “wicked” ones, which no one organisation could possibly deal with on their own. Partnership coalitions are necessary in order to combat these issues and must be led by the public sector because of the values which these moral institutions enshrine.
<i>High Performance</i>	Public sector organisations must become more ‘business-like’ if they are to be more efficient and better able to respond to public demands. This has led to the disaggregation of larger public sector organisations to the local level. Partnerships are necessary to oversee the strategic direction of local areas and to performance manage service delivery organisations within the local area.
<i>Third Way</i>	Partnership is a central tool of the third way political ideology and is necessary in overcoming the limitations of ‘big government’ on the one hand and the free market on the other.

This exercise further illustrates the wide and varied theoretical traditions that are referred to in constructing the problem and solution of partnership. Central government has been largely silent in terms of which theoretical models underpin their push to partnership across a variety of different fields. To some extent this is not surprising; after all it would be a little unusual to see in-depth theoretical accounts laid out within policy documents. However, few researchers have sought to provide definitive accounts of the theoretical models which underpin health and social care partnerships. Sullivan and Skelcher (2002) devote a chapter of their definitive text to exploring the many different theoretical traditions that have been employed in the field of collaboration. In doing so they indicate the vast array of theories and concepts that have been invoked in an attempt to explain why collaboration happens and therefore what it is supposed to achieve. Sullivan and Skelcher's analysis is set out in Table 3.4 and is updated in light of the discussions of institutional theory in chapter two.

Sullivan and Skelcher draw on Challis *et al* (1988) who originally proposed a framework based on optimist and pessimist perspectives of collaboration. Theories of collaboration were characterised according to their motivation or driver to become involved in relationships with partners in the first instance. Optimist perspectives of collaboration are those which presuppose consensus and shared vision between partners, where partners collaborate to produce positive results for the entire system and predominantly for what Challis and colleagues deem "altruistic" purposes. Given this starting point, optimist perspectives often propose that commercial sector organisations might not be sufficiently incentivised to enter into collaboration which benefits an entire system and which they may not necessarily profit from directly in

the short term. It therefore seems to be suggested that optimist theories are those which provide value for the “greater good” and these tend to be associated with public or third sectors, as opposed to the commercial sector. Pessimist perspectives of collaboration, on the other hand, predict that organisations or agencies will only enter into collaboration if they will enhance their own gain or power above anything else. The process of collaboration will only occur if it is in the mutual interest of each party to try control or influence the other’s activities. Individual gain or power is therefore viewed as some form of negative or malevolent force.

Table 3.4: Optimist, pessimist and realist theories of collaboration

	Optimist	Pessimist	Realist
<i>Why collaboration happens?</i>	Achieving shared vision: <i>Collaborative empowerment theory</i> <i>Regime theory</i> Resource maximisation: <i>Exchange theory</i>	Maintaining/enhancing position: <i>Resource dependency theory</i>	Responding to new environments: <i>Evolutionary theory</i>
<i>What form of collaboration is developed and why?</i>	Multiple relationships: <i>Collaborative empowerment theory</i> Coalitions: <i>Regime theory</i>	Inter-organisational network: <i>Resource dependency theory</i>	Obligational, promotional and systemic networks: <i>Evolutionary theory</i> Policy networks as meso level or governance instruments: <i>Policy networks theories</i>
<i>Which factors affect collaboration?</i>	Individual factors: Reticulist skills and abilities, trust: <i>Collaborative empowerment theory</i> Leadership: <i>Regime theory</i>	Organisational factors: Culture, bureaucracy, professionalism: <i>Resource dependency theory</i>	Institutional factors: the mediation of individual and organisational factors: <i>New institutional theory</i> <i>Neo-Durkheimian theory</i>

Based on Sullivan and Skelcher (2002)

This heuristic was further developed by Sullivan and Skelcher (2002: p. 36) who updated the framework to incorporate what they describe as “realist” perspectives of collaboration. The realist perspective is described as a more “nuanced” view than the other two, suggesting that in response to the wider environment both altruism and individual gain may coexist. What is proposed to be important in this perspective is how organisations change in response to the wider environment and how they might achieve either (or both) gains through collaboration. Clearly, the notion of realism has particular connotations in terms of academic research literatures and it is important to point out that what is being suggested here is not an epistemological position as such, but instead more of a ‘pragmatic’ response to the external environment. What Sullivan and Skelcher’s (2002) account illustrates is not just the wide range of different theories that have been used to illustrate why it is that collaboration happens and what it should ultimately achieve, but also reinforces that “good” collaboration is seen to be for altruistic purpose. Yet, as this heuristic also illustrates collaboration is not just an innately good thing and can also exist for individual gain or simply in response to external stimulators.

Powell and Dowling (2006: p. 305) argue that although ‘academic attention given to partnership working...has grown considerably, there have been few attempts to link conceptual models of partnership with existing forms’. The authors employ the theoretical models of Mackintosh (1992) and Hastings (1996) to some of the types of partnership introduced by the New Labour government, concluding: ‘while there are links between actual and model partnerships, there is little evidence that actual partnerships have been designed or structured to meet their particular tasks’ (p. 305). Powell and Dowling are effectively criticising the policy base for partnerships as they

believe there is little in the way of coherent underlying theory about what partnerships should do and what form they should best take to do this.

Chapter one argued that the term partnership had been used to refer to a wide array of different working arrangements and therefore it is not a coherent concept. This chapter has sought to illustrate the lack of clarity within the policy literature about why partnership happens and what it should deliver in practice. Beyond a broad sense of making services better, i has found a distinct lack of clarity and a range of different reasons that partnerships exist and what it is that they should achieve in practice. A similar lack of clarity also runs through the theoretical and conceptual material. Whilst service user outcomes can be charted rhetorically throughout each of these frames, there is often much less relating to these in terms of action. Although all invoke the concept of service user outcomes in order to gain ‘buy-in’ and legitimacy in terms of these frames, the solutions rarely seem constructed purely with the notion of improved service user outcomes in mind. This may go some way to suggesting the lack of evidence of improved service user outcomes set out in chapter one. If health and social care partnerships are not ultimately about improving service user outcomes, then what are they actually driven by? Or in other words; *if partnership is the answer – then what is the question?*

3.7 Chapter Summary

This chapter has identified what are argued to be the four dominant frames within the policy literatures in explaining why it is that health and social care partnerships exist and what it is that they have been set up to achieve. These frames reflect a wide range

of rationales, illustrative of a range of different theoretical and conceptual models. Although central government (and others) have often given improved service user outcomes as the rationale for why we need partnership, this is a driver in these frames often in an abstract and rather unspecific sense. The next chapter turns to the methodology adopted in this thesis in setting out how these issues were investigated in this research project.

Chapter Four: Methodology

'Partnerships are a keystone of current policies to 'modernise' health and social services. This presents new challenges for research and evaluation. 'Partnership' is a vague concept, capable of many interpretations, and its evaluation is therefore problematic, not only for those involved in partnerships but for academics and others with a wider interest in public policy, its governance and mechanisms for delivering services' (Glendinning, 2002: p. 115).

4.1 Introduction

This chapter describes, explains and reflects on the methodological approach adopted in the research which forms this thesis. The chapter starts out by setting out the approach adopted for the research and account of how this developed over time. As this chapter outlines, the research started out in a rather rationalist vein but developed over time to adopt the type of interpretive approach which has been set out in the chapters so far. This research is based on a series of four exploratory case studies, based within a theory-led approach to research that set out to investigate the ways in which partnership had been operated in these locales and the impact this was having in practice. The chapter then goes on to outline the design of the POET process and details how this was employed within each of the case study sites. The chapter concludes by setting out an account of the ways in which the various sources of data were analysed in the research, given that the conceptual basis of the research shifted during the process of data collection.

4.2 Exploratory case study approach

Case studies are the method of choice where ‘the study of phenomenon is not readily distinguishable from its context’ (Yin, 2003a: p. 4). As illustrated in chapter one, previous research has found it difficult to differentiate between the processes and outcomes of partnership given the complexities of the evaluation challenge. Case studies allow in depth analysis into a particular issue in context in order to search for underlying principles (Dul & Hak, 2008). Case studies rely on multiple sources of evidence and may be employed both to test hypotheses and to generate theoretical propositions. As the data analysis section at the end of this chapter illustrates, although this research set out initially to test hypotheses relating to partnerships and service user outcome, in the course of the research this actually became a much more inductive process, generating propositions about the nature of health and social care partnerships.

As alluded to in chapter one, one reason that has been offered for the lack of definitive evidence linking partnerships to outcomes is the wide range of difficulties encountered when researching these entities (Glendinning, 2002; Dowling *et al.*, 2004). This section briefly reflects on some of difficulties in researching partnerships as they were important considerations in the decision to adopt a research approach based on exploratory case studies. Box 4.1 summarises the types of factors which have been identified as challenges in researching health and social care partnerships. Arguably these difficulties are not solely ones which are confined to the health and social care partnership arena: most research into complex social policy initiatives

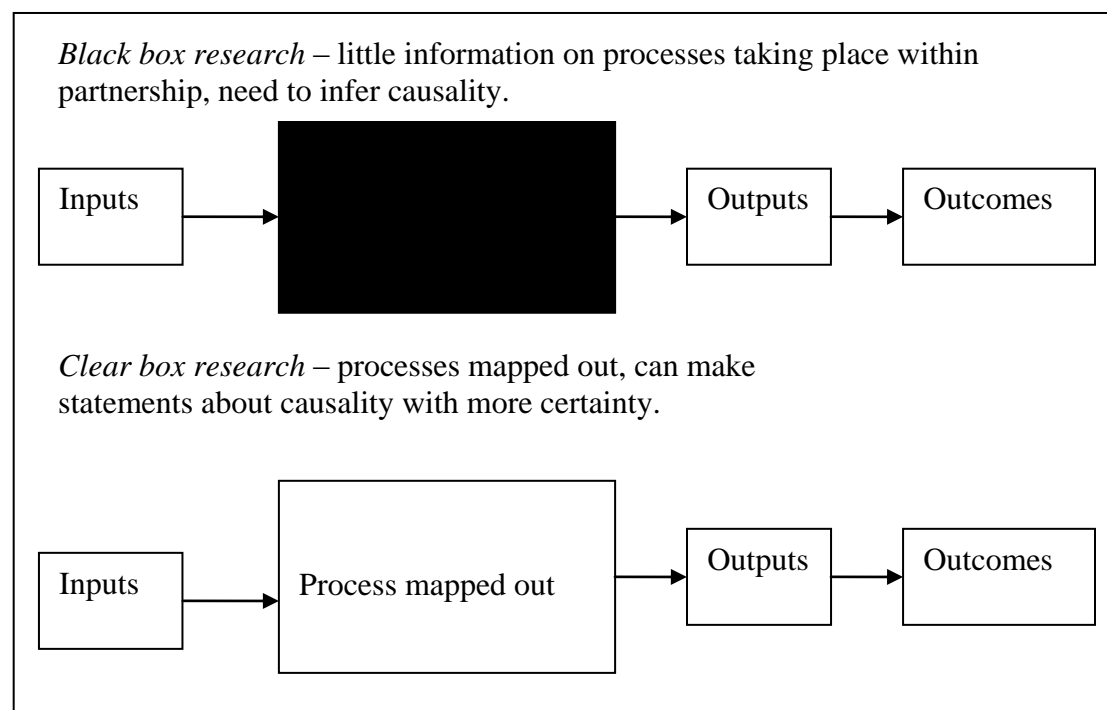
encounter similar challenges. To attribute a lack of evidence of effectiveness solely to these difficulties is perhaps mistaken and there is much to learn from other arenas of social scientific research. These challenges may not be as insurmountable as they are often presented to be, although in resolving these issues research may become so time consuming and expensive that it proves prohibitive. However, discussions of these issues do offer a useful insight into the types of assumptions that have typically been made about partnerships and how they might be researched.

Box 4.1: Challenges of researching outcomes of health and social care partnerships

- Partnerships take many different forms - are we comparing like with like?
- What do different stakeholders consider to be measures of the success of partnerships and what does success look like according to these different perspectives?
- How do the aims of the partnership differ from previous arrangements and from other improvement programmes?
- Where do the agendas of partners overlap and form joint work and what falls outside this collaborative endeavour?
- Which outcome measures are most appropriate to the aims and objectives of the partnership?
- What aspects of context have helped/hindered formation and functioning of the partnership?
- What are the chains of causality/theories underpinning the impact that the partnership is intended to have?
- How can unintended consequences be captured?
- Over what timescales do we expect to see outcomes occur?
- How can we be certain that any changes in outcomes are due to the partnership and not other influences / policies in the local area?
- Is the local population affected by the partnership comparable to that subject to previous service arrangements? Are only the effects on individuals who have received services from the partnership measured?

The types of difficulties that are outlined in Box 4.1 arguably stem from the fact that method-led, empiricist approaches have largely been used to research partnerships. These difficulties are all similar in some respects, arguing that the impact of partnerships might ultimately only be established by being able to identify and confine all the possible effects of these initiatives and control any potential extraneous factors. What these types of approaches have tended to attempt is look at the inputs and outputs/outcomes of a system and make statements about causal links between factors as a result. This type of approach is often referred to as ‘black box’ (e.g. Robson, 1993) and where research seeks an overview of the internal processes (i.e. which ‘open’ the black-box) it is known as clear or white-box research (see Figure 4.1). These approaches fundamentally differ in the way they treat the issue of causality. Black-box research infers causality from observing conjunctions of inputs, outputs and outcomes (i.e. if we put in x, we observe that we get y out which has z effect - therefore we presume that x causes y and z). Clear-box research aims to observe these causal chains in more detail and make more definitive statements about the nature of these relationships (i.e. we have firmly established and can demonstrate that x causes y and z, rather than just being generally associated with these factors).

Figure 4.1: Black box and clear box research



(Dickinson, 2008: p. 54)

The way that causality is conceptualised has implications for the type of approach adopted within research and has been a point of debate within the research literature in recent years. Table 4.1 illustrates the dominant approaches which have been used to evaluate health and social care partnerships, along with a description of their strengths and weaknesses. In the wider research literature, there have long been methodological based debates between advocates of quantitative and qualitative approaches (see for example, Lincoln & Guba, 1985; Campbell & Russo, 2001). In studies of health and social care partnerships, quantitative methods have tended to be used to produce broadly generalisable results over a fairly large population, but tend to encounter a limitation in that they are unable to highlight individual differences

over any large group. Qualitative approaches are proposed to be far more able to accommodate these types of differences, but are more resource consuming and are likely to incorporate smaller sample sizes. However, both quantitative and qualitative approaches encounter difficulties in dealing with issues of attribution (i.e. the ability to definitely state that a particular health and social partnership led to changes in observed outcomes).

The so-called “paradigm wars” tended to debate methodological issues and, as such, this collection of approaches are known as *method-led*. Method-led approaches imply that many of the problems in evaluation result from methodological shortcomings, and that the refinement of research methods alone will lead to the solution of difficulties (Chen, 1990). Chen and Rossi (1989) question the utility of the input-output, ‘black-box’ model of evaluation in which underlying assumptions and principles guiding social action (i.e. theories of continuity and change) are ignored. In their conceptualisation of theory-led evaluation they suggest that black-box evaluations are so because they have no theory and their goals are unclear: the box is empty. In place of methods-based approaches, commentators such as Chen have proposed theory-driven evaluation in which social science theory is employed from the outset. Theory-based approaches clearly identify a series of stages to be followed, including discussing stakeholder views on programmes and examining why and how a programme gets the results it does.

Table 4.1: Method-led research approaches

Approach	Brief description	Strengths	Limitations in practice	Example studies
<i>Randomised controlled trial (RCT)</i>	Seeks to control as many variants as possible in order to isolate relationships between the variables that are the subject of the study. Only by exerting such experimental control can the observer be confident that any relationships observed are meaningful and not due to extraneous forces. RCTs aim to make the comparison group as similar as possible to the group under test so that it clarifies the intervention-specific benefits, but by being randomly chosen eliminates bias.	<ul style="list-style-type: none"> - The ‘gold standard’ within healthcare research, against which other forms are assessed for methodological ‘purity’ in their attempts to eradicate bias (Davies <i>et al.</i>, 2000). - Can cover large service user groups. - Ability to generalise from results. 	<ul style="list-style-type: none"> - Failure to unlock the ‘black box’ and assess the processes within the partnership leading to attribution issues. - Difficulties associated with the randomisation process (particularly ethical considerations in relation to healthcare interventions). - Problems in identifying unintended consequences. 	<p>Comparison of outcomes of different models of day care for older people (day hospital and day care).</p> <p>(Burch & Borland, 2001; Burch <i>et al.</i>, 1999)</p>
<i>Non-randomised comparative design</i>	Seeks to control a number of variants in order to isolate relationships between the variables that are the subject of the study. Only by exerting such experimental control can the observer be confident that any relationships observed are meaningful and not due to extraneous forces. Compares outcomes for two sites selected to be as similar as possible in characteristics or two time periods for same site.	<ul style="list-style-type: none"> - Seeks to eradicate as much bias as possible through experimental approaches. - Can cover large service user groups. - Ability to generalise from results. 	<ul style="list-style-type: none"> - Failure to unlock the ‘black box’ and assess the processes within the partnership leading to attribution issues. - Difficulties associated with identifying homogenous groups. - Problems in identifying unintended consequences. 	<p>Comparison of clinical outcomes of patients served by integrated health and social care teams and more ‘traditional’ GP primary health arrangements.</p> <p>(Brown <i>et al.</i>, 2003; Davey <i>et al.</i>, 2005; Levin <i>et al.</i>, 2002)</p>

<p>Qualitative methods</p>	<p>Tend to take more grounded approaches to research, for example through interviews and case studies of individuals and families. Such approaches tend to reject the ‘naïve realism’ often associated with quantitative methods. That is, a belief that there is a single, unequivocal social reality or truth which is entirely independent of the researcher and of the research process; instead there are multiple perspectives of the world that are created and constructed in the research process (Lincoln & Guba, 1985).</p>	<ul style="list-style-type: none"> - Accommodates multiple user perspectives. -In-depth account of process and context issues. 	<ul style="list-style-type: none"> - Labour intensive, studies tend to be unable to incorporate large numbers of users. -Difficulties in generalising results to other groups. - Attribution difficulties: individuals unable to identify actions and policies and their direct effects. 	<p>Evaluation of multi-agency organisations working for disabled children with complex health care needs to assess their impact on professionals, families and the users.</p> <p>(Townasley <i>et al.</i>, 2004; Abbott <i>et al.</i>, 2005)</p>
<p>Multi-method approach</p>	<p>Combines both quantitative and qualitative approaches to draw on the strengths of each. However, such an approach often involves the researcher ‘hopping’ from one epistemological base (or theory of knowledge) to another (Chen, 1990; Pawson & Tilley, 1997).</p>	<ul style="list-style-type: none"> - ‘A simultaneous multilevel multi-method (quantitative and qualitative) approach to research on partnerships is optimal, thus drawing on differing frameworks and seeking to embrace the perspective of all stakeholders and the complexity of the phenomena under study’ (El Ansari & Weiss, 2006: 178). 	<ul style="list-style-type: none"> - Such an approach does not necessarily overcome issues of attribution. -Epistemological inconsistencies. - Difficulties of consolidating data from different frameworks. - Which stakeholder perspectives should be accepted? 	<p>Evaluation of the first combined mental health and social care provider in the UK, Somerset Partnership NHS and Social Care Trust.</p> <p>(Peck <i>et al.</i>, 2002b)</p>

In recent years, researchers have welcomed theory-led approaches as a means of unpacking some of the complexity of partnerships. Two broad types of theory are explicated in theory-led research: *normative* (how the programme is intended to work, used to check implementation), and *causative* (detailing proposed relationships between variables). This research adopted a theory-based approach seeking to explicate normative theory through the individual exploratory case studies, with an aim to bring the findings from the case studies together in an attempt to build causative theory.

Chen's argument is that unless the causal mechanisms producing programme effects have been understood ('how the programme is supposed to work') it is impossible to apply evaluation findings to other contexts. Theory-led approaches argue that method-led approaches tend to maximise one type of validity at the expense of others (Davies, 2000). Rather than inferring causation from the input and outputs of a project, theory-led research aims to map out the entire process (Pawson & Tilley, 1997) and produce "clear box research". It is proposed that this then allows researchers to say with confidence which parts of the programme worked and why, whether they would be applicable to different situations, and if there are any positive or negative effects which would otherwise not be anticipated (Birckmayer & Weiss, 2000). Without such an understanding, it is argued, it is unclear whether poor evaluation results are due to a failure of programme theory (i.e. the intended causal mechanisms are erroneous) or implementation (the programme did not operate in the way planned so the theory was never really tested).

Theory-led approaches are proposed to be well suited to the investigation of complex programmes or interventions. As commentators like Weiss (1999) and Patton (1997) point out, the sorts of projects which today's evaluators are asked to work on tend to address 'wicked issues'. In these cases, the programme is treated as an on-off switch and we have to distinguish its effects from all the other factors that could lead to an on-off result. Theory-led approaches are viewed as better able to accommodate this level of complexity and to go beyond simply the 'assessment of efficiency in public expenditure and to the identification of added value' which Sullivan and Stewart (2006: p. 196) argue characterises much English experience of evaluative efforts. Moreover, theory-based approaches frequently offer the potential for a more responsive and interactive model of evaluation which seeks to improve the quality of the particular intervention through the involvement of a range of stakeholders (Fetterman, 1994; Sullivan & Potter, 2001). Within such a conceptualisation there is a less distinct split between the problem and solution and the context is seen to shape the type of programme or intervention adopted (and vice versa) in a symbiotic relationship. Table 4.2 provides an overview of the two most prominent theory-led approaches that have tended to be adopted in health and social care: Theories of Change (ToC) and Realistic Evaluation (RE). It is important to note that these are not the only theory-led approaches available, as work by scholars such as Chen (1990) attests to.

Table 4.2: Theory-led research approaches

Approach	Brief description	Strengths	Limitations in practice	Example studies
Theories of Change (ToC)	A ‘systematic and cumulative study of the links between activities, outcomes and contexts of the initiative’ (Connell & Kubisch, 1998: 18). This approach involves stakeholders surfacing the theories underpinning how and why a programme will work in as fine detail as possible, and identifying all the assumptions and sub-assumptions built into this process. ToC are concerned with theorising prospectively, rather than retrospectively (Connell & Kubisch, 1998), with the majority of surfacing exercises taking place during the planning stage of an initiative where there is an opportunity to explore a number of competing theories between stakeholders.	<ul style="list-style-type: none"> - By specifying what will happen in terms of short, medium and long-term outcomes of the interventions ToC seeks to overcome issues of attribution. - Assists in the planning and implementation of an initiative. - In-depth analysis of internal process issues. - Multiple stakeholder involvement. 	<ul style="list-style-type: none"> - External evaluation teams are rarely party to planning discussions in practice, so surfacing activities unable to take place at this point (Sullivan <i>et al.</i>, 2002). - ToC suggest that all the theories and assumptions underpinning a programme be surfaced, but in practice this can result in a number of differing realities being uncovered. ToC demand that one theory should prevail, but this is often not appropriate in practice. - There are a number of practical difficulties in asking stakeholders to articulate such theories in the first place. Many find this an inherently difficult process. 	<p>National evaluation of Health Action Zones (Barnes <i>et al.</i>, 2005).</p> <p>National evaluation of Local Strategic Partnerships (LSPs) (Office of the Deputy Prime Minister (ODPM, 2005).</p> <p>New Deal for Communities (ODPM, 2003).</p>

<p>Realistic Evaluation (RE)</p>	<p>RE suggests outcomes are characterised by the equation (C) Context + (M) Mechanism = (O) Outcome. Pawson & Tilly (1997) argue that no individual-level intervention works for everyone, and no institution-level intervention works everywhere. RE seeks to discover what mechanisms work for whom, and within which contexts.</p>	<ul style="list-style-type: none"> - Overcomes issues of attribution by uncovering micro-level theory. - Identifies which mechanisms work for which individuals, and in which contexts. - Cumulative potential of knowledges of CMO configurations. 	<ul style="list-style-type: none"> - Problems in identifying the outcomes of partnership working. - Problems in identifying mechanisms: Pawson and Tilley (1997) suggest these are often micro-level psychological processes, but they have often been interpreted as grander programmes or theories in practice. - Difficulties in conceptualising context (Calnan & Ferlie, 2003; Dahler-Larsen, 2001). - Difficulties in differentiating mechanisms from context (Byng <i>et al.</i>, 2005). 	<p>Evaluation of Health Education Authority's Integrated Purchasing Programme (HIPP) (Evans & Killoran, 2000)</p>
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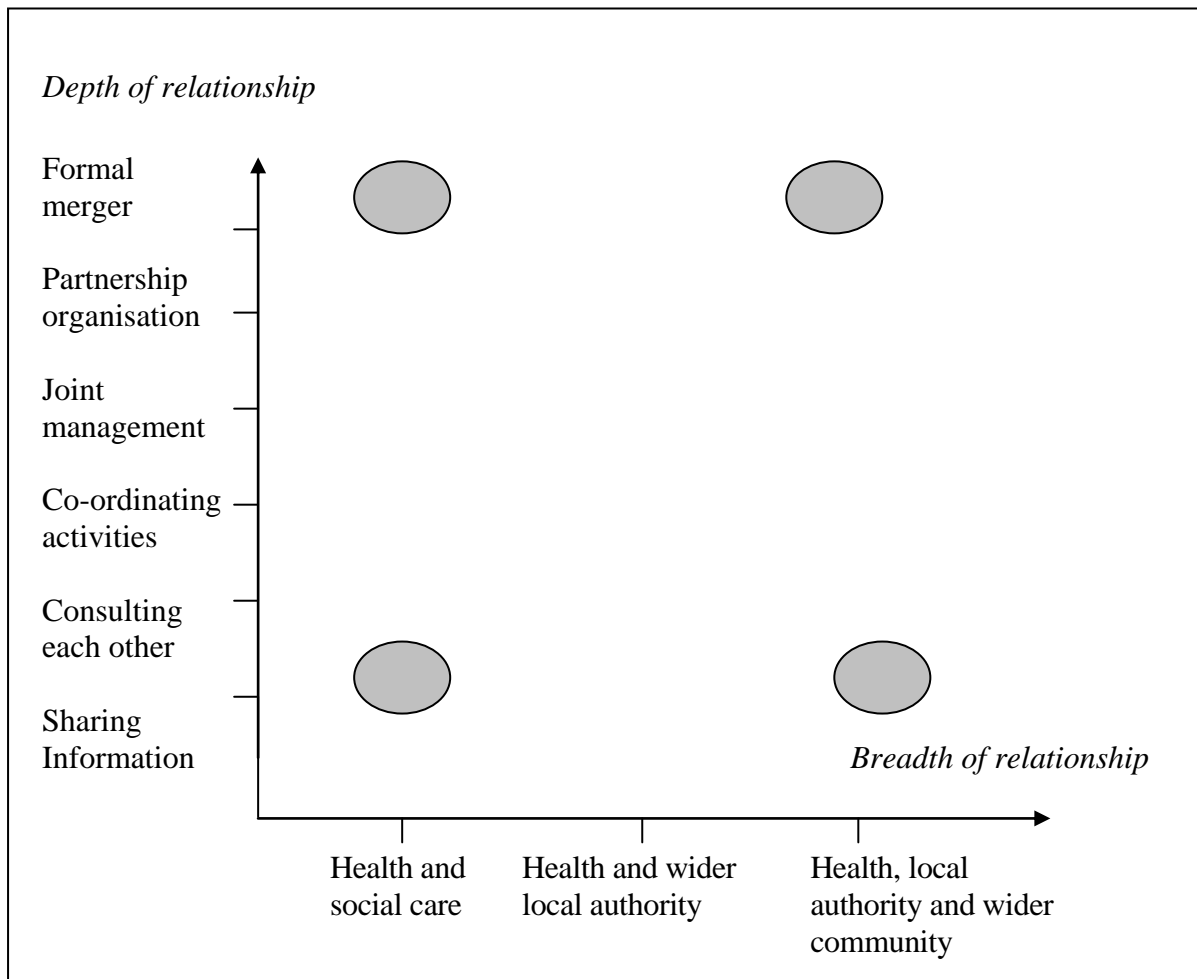
Where theory-based approaches have been used to investigate health and social care partnerships this has largely been through the use of case studies and this was also the approach adopted in this research in order to accommodate the complexity which is reflected throughout the wider literature. The aim of exploratory case studies such as this is to study social phenomenon in their raw form (Glaser & Strauss, 1967). Exploratory case studies generate the type of data which El Ansari and Weiss (2006: p. 178) argue is necessary in order to evaluate partnerships; ‘a simultaneous multilevel multi-method (quantitative and qualitative) approach to research on partnerships is optimal, thus drawing on differing frameworks and seeking to embrace the perspective of all stakeholders and the complexity of the phenomena under study’.

Exploratory case studies allow fieldwork and data collection to be undertaken prior to the definition of research questions and hypotheses which was fitting with the remit of this study. Where there is considerable uncertainty about the operations, goals and results of programmes, exploratory case studies aid identification of questions, select measurement constructs and develop measures for research. This was selected as an appropriate approach given that early indications from the literature review suggested that the field of extant research around health and social care partnerships demonstrated a particularly rationalist approach to the analysis of policy and that this had proved limited so far in making definitive statements about these ways of working and their links to service user outcomes. Investigating case sites through exploratory means would thus allow theory about the nature of health and social care partnerships to be developed during the process of research. One of the greatest

difficulties attributed to exploratory studies is their prematurity; that is, where findings seem convincing enough to be released inappropriately as conclusions.

Given that the term partnership is used to refer to a range of different ways of working, a multiple-case design was selected. The case study sites were targeted and selected based on Peck's (2002) depth-breadth matrix (this has also been used by Glasby, 2005b; Glasby, 2007; Glasby & Dickinson, 2008) so that a broad range of different working arrangements might be covered. Using this matrix the intention was to select four case study sites which broadly mapped on to the extremities of this typology (illustrated by the filled circles in Figure 4.2). This was determined on the basis that this would give a high degree of variety in terms of the types of health and social care partnerships which are found across England. As Stake (1995) recommends, the selection of exploratory case study sites should be carried out so as to maximise potential learning within the pre-identified time constraints. Cases should therefore be selected which are willing subjects; a good instrumental case does not depend on extent of its typicality. The case studies selected were: Rockingborough Integrated Care Services (RISS); Drumston Learning Disability Services (DLDS); the Children's Partnership (CP); and two small teams based at Newfield (ND). Chapter five provides further information about the case study sites and how access was negotiated to each of these sites.

Figure 4.2: “Depth” and “breadth” of partnerships

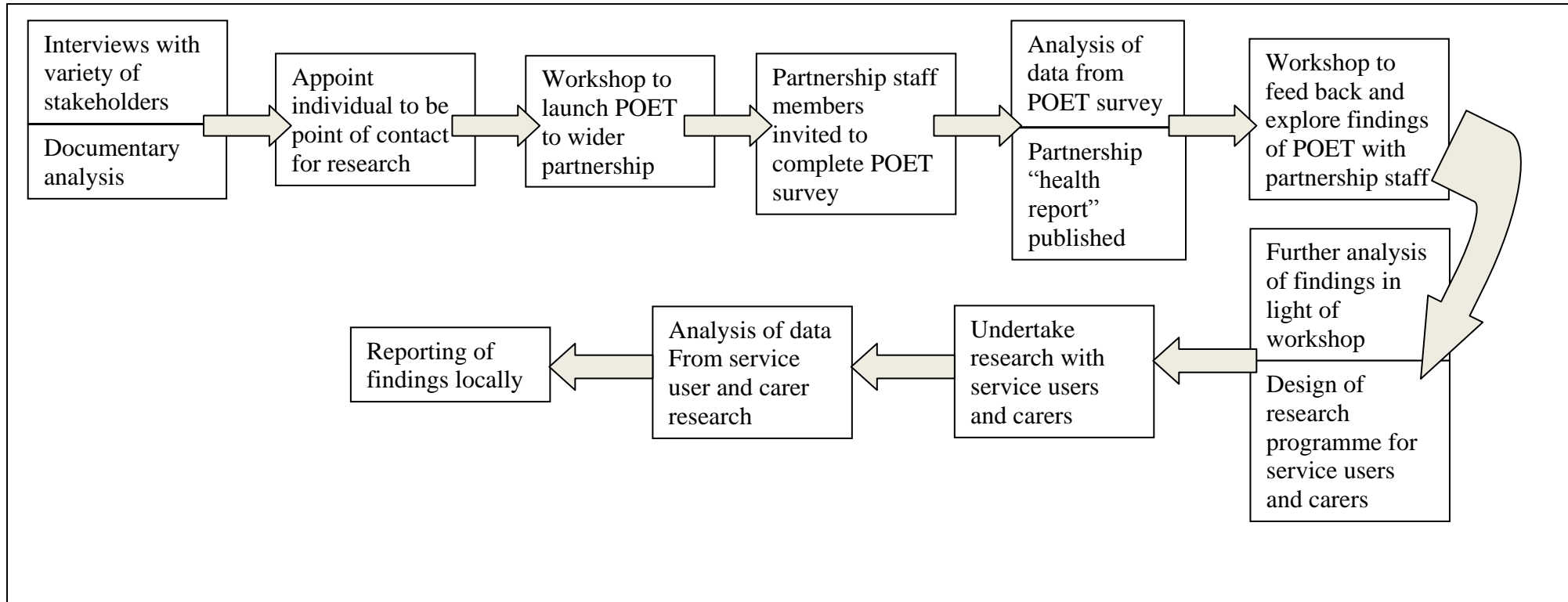


A structured process was developed for the exploratory case studies, so that broadly the same processes of data collection could be followed at each site. This process is outlined in Figure 4.3 and the rationale for the research design is set out in more detail in the remainder of the chapter. This figure had also been reproduced for each of the individual case studies to illustrate precisely what activities took place at each site and the numbers of stakeholders involved at each stage of the various research activities. Yin (2003a; 2003b) argues, case studies lend themselves to theory-based evaluation and with this in mind the process was designed to be formative, giving the individual case study sites feedback through rather than simply reporting summative findings at the end of the research. The formative nature of the research was to some extent also

used as a “selling” point in attracting case study sites. A national call was put out asking for partnerships to volunteer for inclusion in the research. There are more details pertaining to the results of this call in the next chapter, but essentially this stage sought to select partnerships that provided a degree of variety in terms of the organisational arrangements (per Figure 4.2), client group and also geographical location (i.e. not all case studies would be in the same immediate area).

Once the partnerships had formally agreed to be involved in the research, a series of informal semi-structured interviews were conducted with key stakeholders (minimum $n=2$, maximum $n=6$). At this stage this was largely restricted to those actors responsible for the official organisation and oversight of these entities (e.g. chief executives of partner organisations, board members, operational managers). These interviews were accompanied by documentary analysis of any formal and publically available materials in addition to any “grey material” which these contacts were willing or able to offer. The purpose of these initial steps was to gain an insight into the organisational arrangements in place locally, including local histories in relation to why the partnership had come into being and any issues of sensitivity or difficulties which were known to exist locally. These interviews were not tape recorded and transcribed due to their preliminary nature, but extensive notes were taken and a file was compiled for each of the sites containing these notes and any documentary materials that were collected throughout the lifetime of the research.

Figure 4.3: Illustration of process designed for conduct of exploratory case studies



Preliminary interviews were also used as an opportunity to identify an individual within the partnership who would provide a contact point through which to liaise with the partnership. This individual would be responsible for issues such as: negotiating access to potential research participants; helping to organise workshops for staff and service users and carers; securing access to computers in order to fill in the online survey; encouraging individuals to complete the online survey; helping to identify service users and carers to take place in the research; and, in one case conducting some of the interviews with service users and carers. Essentially this individual was a gatekeeper who would facilitate access to the partnership.

The semi-structured interviews and documentary analysis generated some insight into the processes at work within the partnership, but the next stage of the structured process involved gaining a more in-depth insight into the partnership and from a variety of perspectives. There is a tendency in studies of partnerships to concentrate on the data gained through the executive team and board members, but not necessarily at other levels throughout partnerships. The design of this research sought to incorporate a wide range of different stakeholders who operate within the remit of the partnership in order to build up a picture of the complex processes at play within that arrangement. As outlined in chapter one, and as demonstrated in other systematic searches of the literature (e.g. Strandberg-Larsen & Krasnik, 2009), no tools are presently available that are able to evaluate both the processes of partnership and impacts on service user outcomes. A tool was therefore developed for this research that would aim to do just this. This tool provided the main means of data collection within the case studies and is outlined in the next section.

4.3 POET

The Partnership Outcomes Evaluation Toolkit (POET) comprises two stages: the first focuses on collecting data from the staff who comprise the partnership; the second focuses on the service users and carers who the partnership is intended to serve. POET was deliberately designed so that it would collect “thick” data relating to the complex environments of partnerships and to fit well with an exploratory case study methodology. The first phase of research explores the processes of partnership working from a range of perspectives across the partners. It is designed to highlight where things work well and also the difficulties that are involved. Given that there is little clarity over what it is that partnerships should achieve in terms of service user outcomes this process is also designed to explore perceptions of what it is that the partnership is ultimately aiming to achieve in terms of service user outcomes. Built into POET is a process to surface normative theory about what the partnership is aiming to achieve in terms of service user outcomes. Appendix Two contains screenshots of the POET survey and illustrates what it looks like to the individual completing the survey. Having established the purpose of the working arrangements, the second stage is designed to investigate these outcomes in more detail and determine whether these have been achieved in practice. The next sections provide a more in-depth view into these processes.

Survey

As set out above, this component of the research has two distinct aims:

- Test the “health” of the partnership. The survey comprises a series of attitudinal and open ended questions relating to their experience of operating within the partnership. It is intended that this process should highlight areas which staff feel comfortable with and those which are not experienced in a positive way. It is important to note that this process is predominantly intended to be developmental, rather than evaluative, in the sense that the outcome of this process is not intended to produce results for individual partnerships so that they might be compared against the scores from another.
- Surface assumptions about what it is specifically that the partnership is attempting to achieve in terms of service user outcomes.

A search of the literature relating to the processes of partnership working and the content of existing “health assessment tools” were drawn on to set the questions that appear in the survey and which interrogate how it feels to operate within the partnership. In order to elucidate the outcomes that the partnership is aiming to achieve, a section was modelled on a Theories of Change approach. This ultimately sought to uncover the many (possibly conflicting) ideas about how the partnership (programme) should work.

In order to make this tool applicable to the range of potential forms of health and social care partnerships it was recognised that whilst some experiences might be the same across all sites others could be vastly different. The existing health assessment toolkits (e.g. Hardy *et al.*, 2003; Markwell *et al.*, 2003) are relatively similar in their

analysis of what makes partnership working “effective” (in a process sense) and these are also highlighted in other reviews of the literature (such as Cameron & Lart, 2003; Wildridge *et al.*, 2004). Given the convergence around these factors it was anticipated that these could be used as the starting point for discussions about experiences of partnership, although without being as prescriptive as some of these assessment tools tend to be. However, in terms of what individual health and social care partnerships are set up to achieve it was acknowledged that this was likely to generate many different responses, depending on the scope, service area, and structures of the local working arrangement.

The questions which form the survey are split into four main sections. The first section asks for information in relation to: the individual’s role title; which partner they are employed by, and; whether they identify with a specific professional group. The following three sections then pose questions around: how the partnership feels at the level of the individual; the means and modes through which the partnership is organised; and, finally a series of issues relating to service user outcomes. The survey questions are predominantly composed of attitudinal statements where respondents are asked to rate on a five-point Likert Scale (ranging from *strongly disagree* through *disagree*, *don’t know*, *agree* to *strongly agree*). There are a number of debates over the use of Likert scaling, but one main point of debate relates to whether or not a central point should be offered (Garland, 1991). One school of thought suggests that where a central point is offered it is more likely that respondents will choose this option rather than spending time considering their response in detail (Worcester & Burns, 1975). Where there is no central point it forces respondents to make a decision about their feelings in relation to that issue one way or another

(Matell & Jacoby, 1971; 1972). For this survey a central point was employed because, as noted above, it could potentially be the case that not all of the questions in the survey would be applicable to every setting. In the guidance material respondents were asked to try not to use this central point unless they did not understand the question or it was not applicable to their particular setting.

In addition to rating attitudinal statements, respondents were provided with free text space to include any comments they may wish to make in relation to a particular question and they were encouraged to provide this where a particularly strong or weak response option was selected. There are also a limited number of open-ended questions within the survey, particularly when asking respondents to surface their assumptions about the outcomes that their partnership is trying to achieve for service users. The survey is supported by a range of prompts with examples and explanations of the meanings of the questions. Given that the survey asks for quite a lot of information and it was anticipated that the process of articulating outcomes may be challenging, the research was introduced at each case study site by holding a launch event. At these events the purpose of the research was set out, an overview of the survey provided and a “question and answer” session dealt with any queries or concerns which individuals might have in relation to the overall programme of research.

Once the responses were collated, they were analysed using basic descriptive statistical analysis processes and the accompanying free text comments were used to highlight more in-depth perspectives. The type of data gathered from the attitudinal responses is ordinal or categorical data, rather than cardinal data. This is important as

it has implications for how it might be analysed and used in practice. One implication is that it is incorrect to try and provide an arithmetic mean for these responses. Although statements are attributed a number (one is '*strongly disagree*' through to five which is '*strongly agree*') to add all the responses to a specific question together and divide by the total number of responses to produce a mean gives a figure which is not meaningful. Given that the responses are discontinuous data, one figure cannot be derived to sum up the perceptions of the whole group who respond to a question. The actual meaning of a '4' or a '2' response will vary from person to person (i.e. person X's interpretation of '*strongly disagree*' may actually be qualitatively different from person Y's interpretation of '*strongly disagree*'). So it follows that this data cannot be analysed using techniques for cardinal data.

In practice this also means that it is not meaningful to compare the perceptions derived from one question with another; neither is it meaningful to compare findings between case study sites with definitive statements about one partnership functioning more "effectively" than another. Outside of the free text, the responses are predominantly situated and subjective and therefore represent a snapshot in time, rather than a definitive statement of "truth". They reflect the ways in which stakeholders make sense of partnership within their specific settings and the situated meanings they ascribe these processes of local change. Therefore this process is intended to be developmental, rather than evaluative *per se* and the assumptions underpinning the activities of the partnership and the outcomes which it aims to achieve are then further explored within the second stage of the POET process. The final part of this section provides detail about theories of change as this was the approach used to surface assumptions about the partnerships' activities.

The US Aspen Institute Roundtable on Community Change developed the Theories of Change approach; a theory-based approach to the evaluation of comprehensive community initiatives (Connell *et al.*, 1995; O'Connor, 1995). Contrary to Chen and Rossi, Weiss (1995) suggests that all programmes have explicit or implicit theories of change about how and why a programme will work, that influence decisions around programme design. The black-box is not empty; rather, it is full of many theories, which take the form of assumptions and tacit understandings. These are supplemented by the many (possibly conflicting) ideas about how the programme should work held by implementers and stakeholders. The role of the evaluator is to bring these theories to light and reach a consensus on which need to be tested. These theories are used to develop a research plan that tests whether the programme's theory holds up when implemented.

Programme theories thus form the kernel of the evaluation. Two components are identified: 'implementation theory', which forecasts the steps to be taken in implementation; and 'programmatic theory', based on the mechanisms which make things happen. Theory-based evaluation highlights these mechanisms, and uses data to test them, helping to generate new theories in turn. Similarly, Connell and Kubisch (1998) describe the theories of change approach as the articulation and testing of a programme's desired outcomes, and the timescale for these to be achieved, together with the processes whereby these will be arrived at, making adjustments to methods and goals along the way. Thus, this is an approach to research which is seen as reconciling processes and outcomes (Hughes & Traynor, 2000).

A variety of techniques for identifying implicit programme theories have been suggested by researchers. The *policy scientific approach* (Rossi *et al.*, 1999; Leeuw & van Gils, 1999) describes steps in which statements are derived from programme documentation and interviews, diagrammatic representation of underlying theory, surveys of statements linked to goals, and validation through checks for logical coherence. While this multi-method approach helps to provide a rich assessment, it can be cumbersome and time-consuming, and there are fears that social and behavioural dynamics may not be fully articulated. In contrast, the *strategic assessment approach* ('assumptional analysis') (Jackson, 1989) emphasises dialogue, and requires involvement of a wide range of stakeholders in group-based discussions to surface programme assumptions, rating their importance and the degree of certainty with which they are held to be correct. Groups make the case for the programme, identifying the key assumptions, followed by open dialectical debate, focusing on the assumptions which differ between groups. An attempt at synthesis is made, but if synthesis cannot be achieved points of disagreement are noted and implications discussed. The biggest weaknesses are that the criteria used for assessing the validity of assumptions are unclear, and the impact of group dynamics is not addressed.

Finally, *elicitation methodology* (Eden & Spender, 1998; Weick & Browning, 1986; Argyris & Schön, 1978) may be used to elicit the cognitive models ('mental maps') influencing behaviour. Underwritten by cognitive and organisational psychology, maps may be elicited through a consideration of documentation, listening to decision-making in action in critical circumstances, and using interviews to probe 'theories in use' (Van der Heijden & Eden, 1998). While assumptions are more likely to be

revealed in critical circumstances, validation of these assumptions is difficult, and use of incorrect assumptions ineffective.

While these approaches differ in terms of the data they employ and techniques to elicit perceptions of stakeholders, all use documents and interviews and make use of existing research to check for consistency. All could be applied to the same evaluation. It could be argued that the policy-scientific approach is best used for *ex post* evaluations of programmes backed by documentary evidence, while strategic assessment and elicitation approaches appear more relevant for *ex ante* evaluations. POET is designed around a strategic assessment approach. However, there is a slight variation in that individuals outline their theories and these are then brought to groups in workshops at which point discussion takes place with the aim towards forming a synthesis that might then be tested out in the second phase of research.

The survey section of the toolkit is hosted online to speed up data collection processes. All identified participants were invited by email to complete the survey and were given a personalised user name and password which only they have access to. All data gathered through the survey is therefore anonymous. Previous research has shown that such a level of anonymity tends to encourage individuals to give more honest responses, because the data is non-attributable and also because people do not feel compelled to give the types of answers they are expected to give (e.g. Langbein & Felbinger, 2006). However, this does not mean that all responses will reflect accurate or “true” representations of the perspectives of the individuals completing the survey.

Service user and carer research schedule

Phase one explores aspects of the “process” of partnership working and elicits an understanding of what stakeholders believe the partnership is aiming to achieve in terms of service user outcomes and broadly followed the same process regardless of the partnership being researched. The shape of the second phase is therefore dependent on: the findings from the first phase; the size and scope of the partnership; and, the type of services provided and to which service user groups. Ultimately the aim of the second phase is to investigate two specific issues: whether the outcomes outlined through the first phase of the research are the “correct” ones in the sense that they are what service users and carers actually want the partnership to deliver; and secondly, the degree to which the partnership is actually achieving these outcomes in practice.

It was anticipated that a range of different methods might be adopted in this second phase; ranging from quantitative research into particular outcome indicators through to focus groups or interviews with service users and carers. However, as chapter five illustrates, when the research was undertaken, the first phase proved rather more difficult and as a consequence the second phase of research did not take place in the manner envisaged. The difficulty evident in identifying outcomes challenges the implicit assumption that these were the primary driver of the partnership arrangements implemented. Therefore, the second phase did not take place as was initially envisaged in most of the case study sites. Given that an exploratory case study approach aimed to eliciting thick description of the sites had been adopted, the data

collection methods remained the same, whilst the analytical framework developed (and this is discussed further in the following section). Before moving on to provide more detail in relation to the data analysis techniques employed in the research, there are a series of diagrams based on Figure 4.3 that show the actual research process undertaken at each of the case study sites. These diagrams are expanded on further in setting out the findings of the research in chapter five.

Figure 4.4: Process of research at Rockingham Integrated Care Service

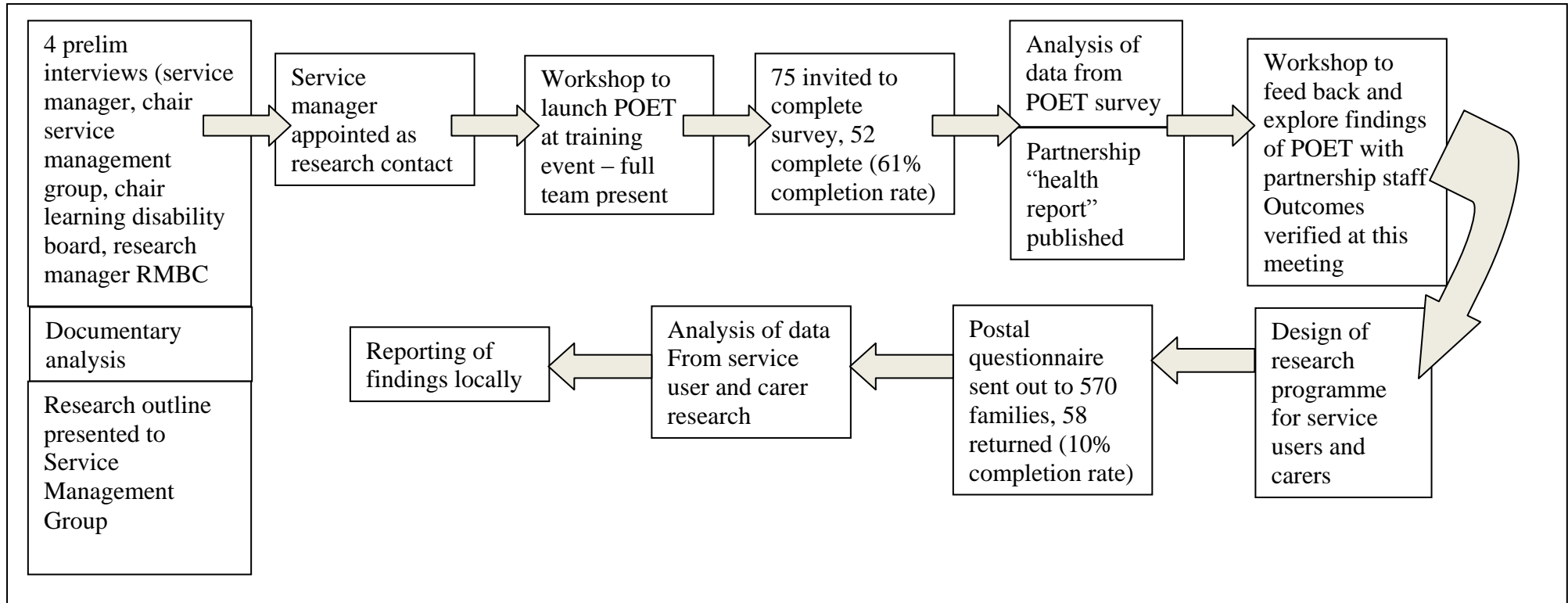


Figure 4.5: Process of research at Drumston Learning Disability Services

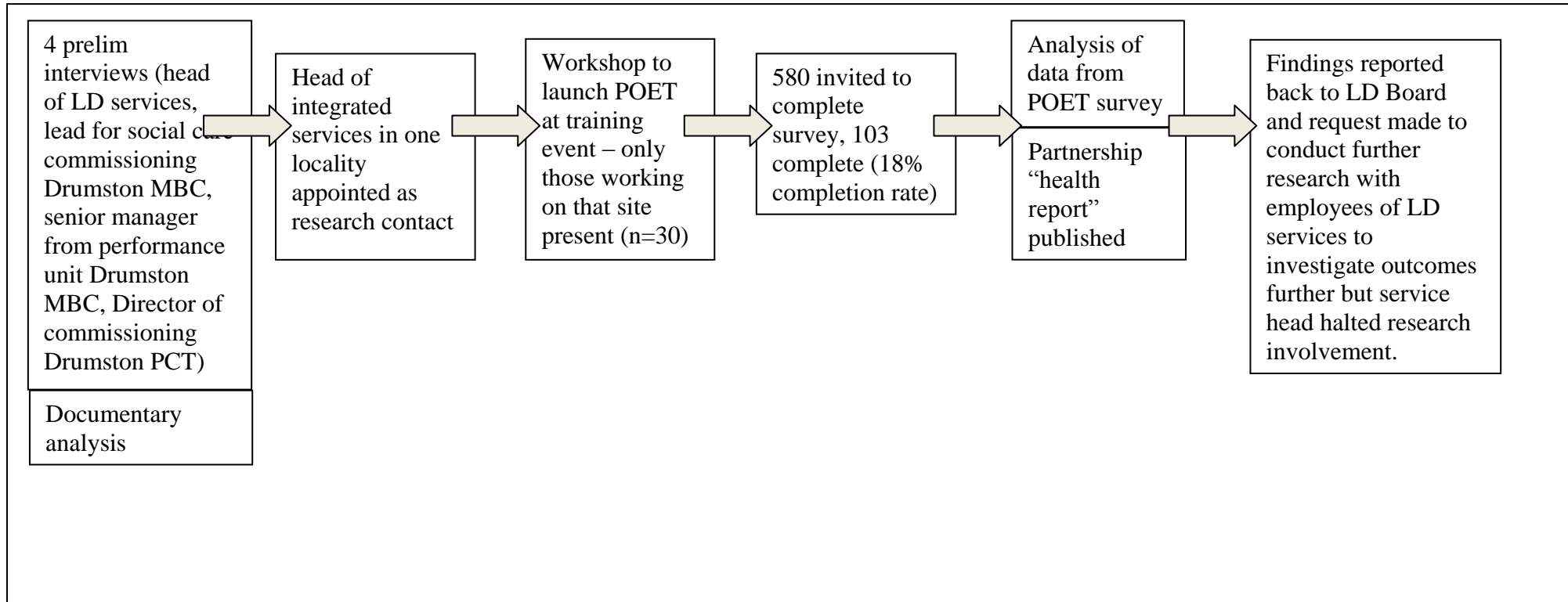


Figure 4.6: Process of research at the Children’s Partnership

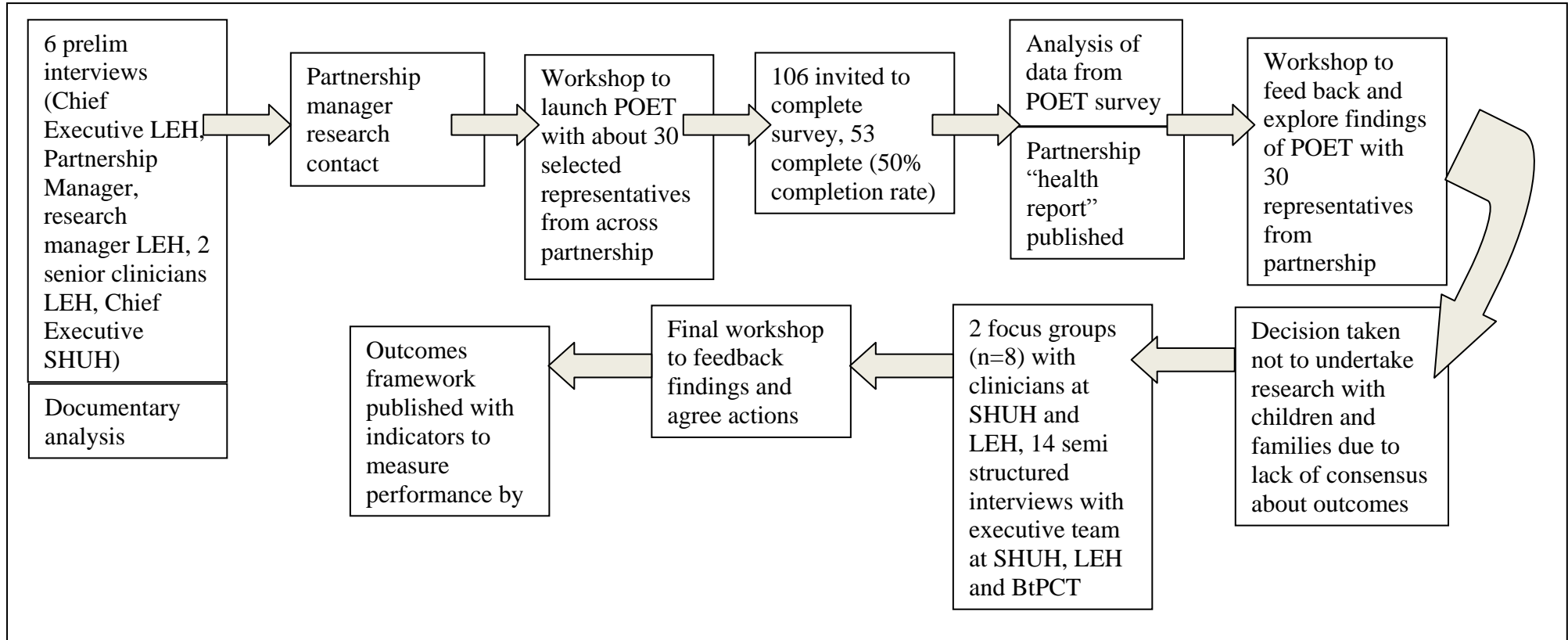
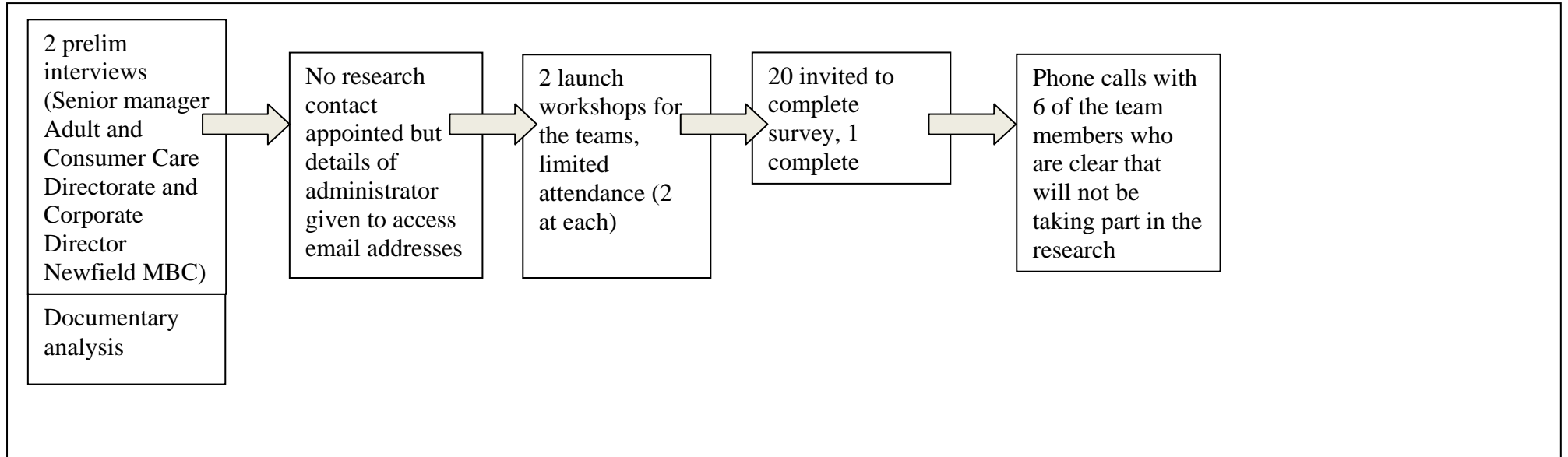


Figure 4.7: Process of research at Newfield

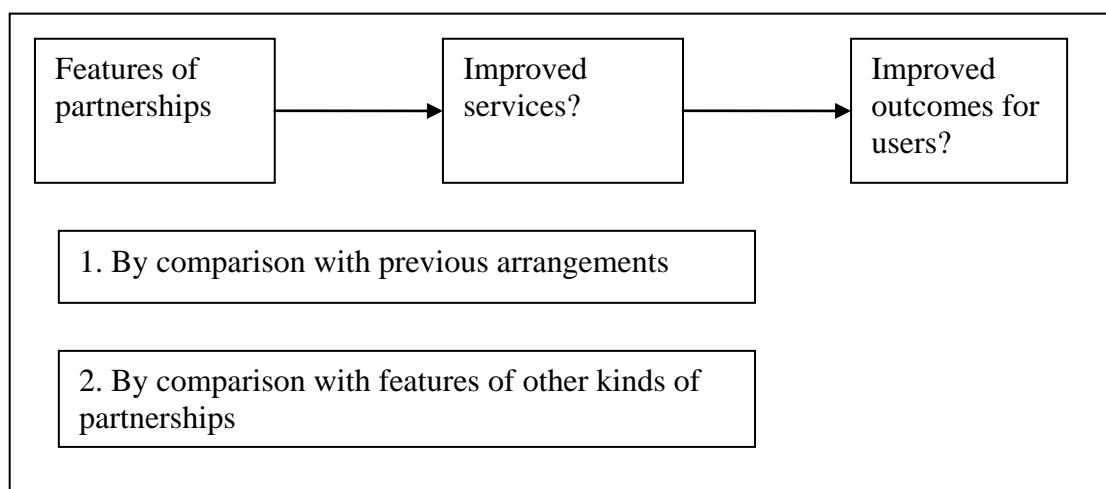


4.4 Data analysis

As has been alluded to already in this chapter, over time the theoretical basis of the research developed which had implications for the ways in which the policies of partnership were conceptualised and therefore the way in which data were analysed within the project. The study initially set out to with a fairly broad remit to test whether the assumption that health and social care partnerships improve service user outcomes is true (illustrated in Figure 4.8). At this point the major research questions included:

- Is there evidence that service user outcomes had been improved as a result of partnership?
- If so, how does this compare to previous service delivery arrangements?
- How do impacts compare between different types of partnerships?

Figure 4.8: Initial research framework



Given that relatively little was known in the wider literature at this stage about the linkages between the processes and outcomes of health and social care partnerships an approach was designed based on exploratory case studies. As suggested previously, one of the major evaluative difficulties associated with health and social care partnerships is that central government has been unclear about *which* outcomes they were aiming to produce. Aside from a notion that this is generally a positive thing that aims to make services better - and consequently service user outcomes better - there is little more specificity about *what* will be made better, *how* and the underlying assumptions about *why*. POET was designed to facilitate the investigation of both the processes of working within a partnership and also surface the range of assumptions pertaining to what partnerships are expected to achieve in terms of service user outcomes.

In practice, the strategy of encouraging stakeholders to surface outcomes proved rather problematic (as illustrated in Figures 4.4-4.7). On reflection the research up to this point had taken rather a 'rationalist' approach – which is characteristic of the types of research which has tended to be conducted in this arena. Government stated that partnerships should improve services and therefore service user outcomes, so the research had set out to test this link. Yet, the problem with this approach is that it makes the assumption that the purpose of health and social care partnership *is* in making a difference in terms of service user outcomes. What was found in practice was less clarity that this was the case in practice.

Given these observations, the research questions developed and the focus shifted from attempting to test causal links between health and social care partnerships and service

user outcomes, to examining the ways in which a particular policy has been employed in a range of local settings and what this revealed about the symbolic and rhetorical values of this policy. This shift has implications beyond simply the focus of the research questions which form this thesis and there are also a range of methodological and analytical implications that arise. Although the overarching approach of exploratory case studies remained, the focus of the research and analytical techniques employed developed somewhat. Table 4.3 illustrates the development of the research programme over time summarising the methodological considerations underpinning these developments and the specific approach adopted in the research.

Table 4.3: Development of the research programme over time and associated conceptual and methodological implications

	Conceptualisation of research at outset	Conceptualisation of research after further development
<i>Primary research question</i>	Do health and social care partnerships lead to improved services and improved outcomes for service users? If so, how does this compare with previous arrangements?	What are the drivers of health and social care partnerships? How have these mechanisms been utilised nationally, and enacted locally, to frame which kinds of issues and to what ends?
<i>Model of policy analysis</i>	Rationalist, instrumental.	Interpretive, focusing on institutions and the importance of socio-cultural values
<i>Implicit assumption</i>	Health and social care partnership are intended to improve service user outcomes.	Health and social care partnerships not driven solely by improving service user outcomes. Rather, policy has symbolic and rhetorical values which can be used nationally and locally to frame issues in particular ways and engage local stakeholders in processes of change.
<i>Performance focus</i>	Efficiency and effectiveness.	Efficacy.
<i>Issues under empirical investigation</i>	<ul style="list-style-type: none"> • What different forms of health and social care partnerships exist and how do their features differ from one another? • Do health and social care partnerships lead to improved services? • Do health and social care partnerships lead to improved outcomes for service users? • If health and social care partnerships do improve services and outcomes, which features of these partnerships produce these impacts? • Do all health and social care partnerships have the same kinds of impact on services and service user outcomes? • How do services delivered by health and social care partnerships and service user outcomes compare with previous (i.e. “traditional”, single-agency) arrangements? 	<ul style="list-style-type: none"> • How has the term ‘health and social care partnership’ been used nationally and in response to which issues? • How has the term ‘health and social care partnership’ been used locally and in response to which issues? • What do local health and social care partners suggest they are trying to achieve in terms of impact on service user outcomes? • What drives the formation of health and social care partnerships at a local level? • What aspects of symbolism are invoked in the deployment of partnerships? • How is rhetoric invoked in the deployment of partnerships?
<i>Analytical focus</i>	Linear, causal impacts.	Discursive framing of problems and solutions and the symbolic and rhetorical value of particular factors and/or actions.
<i>Deployment of POET</i>	Primarily as a means of eliciting assumptions about service user outcomes which can then be tested for causal links to indicators.	Formative, developmental tool used to identify a range of discursive framings pertaining to meaning making around partnerships.

The remainder of this section focuses on the implications of these developments in terms of the analysis conducted within the research. During the first phase of research some basic descriptive statistics were used to present the various attitudes of stakeholders within and across partnerships and supplementary data from the open ended questions was also used to support these analyses. However, given the difficulties with articulating the types of outcomes that the partnerships were trying to achieve, the conceptual grounding of the research shifted and the data from the case studies were re-analysed through an interpretive lens (see Yanow, 2000b for a detailed exposition of this type of approach). Interpretive analysis on the types of meanings that policies embody for different stakeholders and how they go about articulating this meaning for others. Such an approach focuses on the types of values, beliefs and feelings that individuals and groups communicate. In doing so, interpretive analysis examines the embodied action of individuals and groups in living out processes and practices within their local contexts. The interview notes, documents collected and any other data sources associated with the sites were returned to and coded according to themes around the types of values and beliefs expressed in relation to the notion of partnership within their local context.

POET was designed as a tool to investigate the lived experience of individuals working within particular partnership settings, and as such, generated richer and more in-depth data than previous evaluation tools that have been tested for their reliability and validity in inter-agency settings (e.g. Center for the Advancement of Collaborative Strategies in Health, 2006; Anderson & West, 1998; Butt *et al.*, 2008). Moreover, this data collection exercise did not take place in isolation. POET is essentially an entry point into discussions and debates about the lived experiences of these working relationships and the links between health and social care partnerships and outcomes. Additional interviews, workshops and focus groups were

variously employed within case study sites to: reflect on findings; validate and explore results and conclusions, and if necessary; change or refine the logics about partnership working in these locales.

The re-analysis of this material focused on investigating the situated meaning ascribed to the notion of partnership. An interpretive analysis views actions and policies as an expression of meaning, and not simply as rationalist and goal-orientated instruments for bringing about particular changes (Fisher, 1997; Yanow & Schwartz-Shea, 2006). It focuses, in this case, on what is meaningful to those actors engaged in processes of partnership working via the use of narrative analysis. Applying this form of analysis to the study of partnerships allows the engagement of values and feelings (or sentiments) – ‘those very human, expressive qualities that are part and parcel of policy problematic - along with the more cognitive, rationalist side of human life’ (Yanow, 2007: p. 116).

Such a schema sees meaning as conveyed through the use of metaphoric and narrative processes that bring together different experiences and ways-of-doing based on feelings, values and beliefs, which often dictate a certain course of action through physical objects and ritualistic acts. Employing such an analytical approach within the different case study sites allows the researcher to view the meanings given to these stories within partnership settings, providing insights, ‘in relation to policy, particular narratives structure and limit what may be told or said and how reality is thought represented and acted upon...narratives are not free floating but linked to political formations and institutional organisational forms’ (Atkinson, 2000: p. 213). In this way, interpretive analysis was used to uncover the meaning attributed to partnerships within the different case study settings and the impacts that this had on the

formulation of activities and constraints within particular institutional settings by a variety of different stakeholders.

All the notes that had been made from interviews, workshops, focus groups, emails sent to the researcher by different stakeholders and the responses to POET were revisited to analyse the types of narratives which individuals had articulated about partnership working within their local setting. In the process, the material was coded according to the deductive-inductive approach recommended by Miles and Huberman (1994) where the frames identified from the national policy context and set out in chapter three were supplemented by inductive codes which were linked to the issues that arose out of the specific locales and those relating to values and feelings of individuals. If partnerships were not simply driven by a need to improve service user outcomes then what were the alternative drivers? Were the partnerships that had been formed what stakeholders expected or was their local instantiation somewhat at odds with what they had originally anticipated? Central to this analysis was the multiple and varying accounts of local actors in relation to both: the problems which they believed “partnership” was intended to address, and; how they perceived implementation actually took place.

4.5 Chapter Summary

The lack of evidence relating to health and social care partnerships and outcomes for service users is not a product of a lack of evaluative activity. Much of the existing research into health and social care partnerships highlights the difficulties inherent in evaluating these entities. Yet, this chapter has argued that many of these difficulties reflect the widespread adoption of more traditional models of policy analysis which have informed the

methodological approaches used to evaluate partnerships. Grounding research within an interpretive conceptual model offers possibilities outside of these constraints and ones which it is argued are more helpful in examining the everyday experience of partnerships.

The chapter has set out an account of the methodology adopted within this thesis, linking it to the conceptual roots of the study and the narrative of change which has occurred throughout the lifetime of this endeavour. The chapter has outlined the case for (and use of) exploratory case studies and the design and development of the POET tool which was specifically produced in order to evaluate the health and social care partnerships selected within this research. Although the conceptual underpinnings of this research shifted following early data collection, this data could still be used to investigate these new developments albeit by adopting a different analytical approach. This chapter has set out the broad contours of an interpretive approach to analysis, drawing attention to the importance of the ways in which stakeholders describe their everyday experiences of these working relationships.

Chapter Five: Findings

“There is no evidence i.e. hard data that I have seen that the partnership has made a difference for the children.” (Interview with senior clinician, Lower Easingham)

5.1 Introduction

This chapter sets out the findings of the research generated through the exploratory case studies. As outlined in chapter four, in all of the sites the process of the research was much more difficult than had originally been envisaged because respondents found it problematic to articulate the types of outcomes that their partnership was attempting to achieve for service users. However, at two sites these difficulties were particularly pronounced and the process of research practically halted in these cases. Under a more “traditional” approach to research this might be considered problematic but an interpretive reading instead suggests that this inability provides quite different evidence about the nature of partnership and the implementation of this as a policy within these settings. Rather than partnership being an instrumental approach which is adopted in response to readily identified areas of improvement to service user outcomes, they were being advocated for rather different reasons.

Given the nature of this analysis the case study sites reported in this research have been anonymised so that they are not readily identifiable. Some of the analysis presented in the next chapter could be interpreted as critical of individual sites (although this is not the intention and any critique made is primarily of the policy context). However, given the

sensitive nature of some of the issues covered in this, and the following chapter, the case study sites have been given different names in order to protect their identity. In this chapter each case study site has its own section which sets out: a brief overview of the partnership and local context; an account of how access was negotiated; an overview of the research conducted and the key messages which this produced. Details of the case studies are set out chronologically in the order which the research programme was embarked upon. Some sites are afforded more space than others as they were more engaged in the process of research and therefore there are more research activities to report on. The final section in this chapter sets out a series of common themes which were uncovered through the process of research and this provides the basis for the analysis set out in chapter six.

5.2 Recruiting case study sites

In early 2006 a call was put out to all members of the former Integrated Care network, which was hosted by the Department of Health as part of the Care Services Improvement Partnership. The call stated that the Health Services Management Centre had designed a new evaluation toolkit which would be used to help local sites examine how well they were doing both in terms of the processes and outcomes of partnership working. It stressed that the research team were looking for many different types of health and social care partnerships (i.e. in terms of size, role and remit) and that this process formed part of a PhD project. Around thirty responses were received from health and social care partnerships around the country. Informal interviews were conducted with each of these sites to better understand the local arrangements which were in place and it was requested that the sites also send an email setting out these arrangements in writing. These were used to map out characteristics of the

sites and compare them to one another so that a mix of case study sites could be selected according to the framework set out in the previous chapter (Figure 4.2).

A number of the emails and calls that were received started with an introductory line of “my boss passed this email on to me and says this is something we should be involved in because we have a good partnership and it would be good to show people this”. Some responses were received from sites who were interested in being seen as being evidence of good practice:

‘We have external evaluators working with us and we have been talking about staff and user surveys with them. We would be interested in being part of POET as it would fit in really well with what we're already doing and people are up for the partnership to be evaluated. The partnership working has already developed quite well and by the end of the year we should be seeing the effect at the frontline staff services come on stream in the next month or so’.

Like this example, many of those who responded were already involved in other evaluations of their partnership arrangements and were interested in taking every opportunity to gain feedback and be seen as exemplar projects. Yet, there were a range of other reasons expressed in wishing to become involved in this programme of research.

Some of these partnerships were just about to launch and they viewed the evaluation as a means to persuade partners to engage in the process of building partnerships. One such example wrote:

‘Helen...just wanted to put in a plea for the [partnership] in particular. I'm part of an LD Executive for the [partnership] which was until recently was a partnership between Social Services and 6 PCTs. We will shortly be funded by a single PCT but have key aspects of partnership working that your tool kit would help us develop. We have some unique pressures in that - we have a large city population we have market / coastal towns and more rural areas. In addition, lots of people retire or are placed in [place]

and as a result we have a large imported population. Our close proximity to [place] means we can use your work to examine some of the lessons learned from the recent investigation and see how your work can influence future developments’.

In this example, the respondent seems to be suggesting that evaluation would put a spotlight on partners and this would encourage them to further engage in partnership activities in a context of structural change. Independent evaluation would force partners to further commit to produce a partnership which was envisaged would overcome these difficulties and in a way that they may otherwise neglect to do so. The emotive language putting in a “plea” to be involved in the research is interesting but not unusual in terms of the responses received.

Some of the respondents explained they were working through some difficult processes locally and wanted to be able to show some form of recognition to partners who had engaged to reconfirm that the effort they had put into these arrangements were worthwhile. One such respondent stressed the arduous process which she and her local authority counterpart were going through in an attempt to launch a particular partnership aimed at providing services to older people. She felt that she was not getting the attention of the executive within the PCT, but that evidence from an evaluation may help her to do so. In talking about the successes that she had so far managed to achieve in order to illustrate her plight, she wrote; *‘whilst this may seem very trivial both myself & my SS "partner" have organised reciprocal parking permits!!!’* What she ultimately wanted was recognition of the difficulties which she was fighting against locally and felt some more senior buy in to hopefully make this process more straightforward in the future.

What these responses demonstrated was the wide variety of partnership activities taking place across the country and the level of challenge which senior and middle managers often face in attempting to implement these arrangements. Yet, it seemed from responses that establishing

a partnership does not necessarily mean the difficulties end. There were a number of examples where keeping various staff and stakeholder bodies involved and committed was a challenging endeavour and this was another driver to wish to become involved in the project.

Despite the occasional mention that local partnerships were driven by the aim of making outcomes better in a very general sense, no health and social care communities got in touch to suggest that they were making a difference in terms of service users and so wished to engage in this process to demonstrate this. The response which articulated greatest concern for service user outcomes came in the following extended quote:

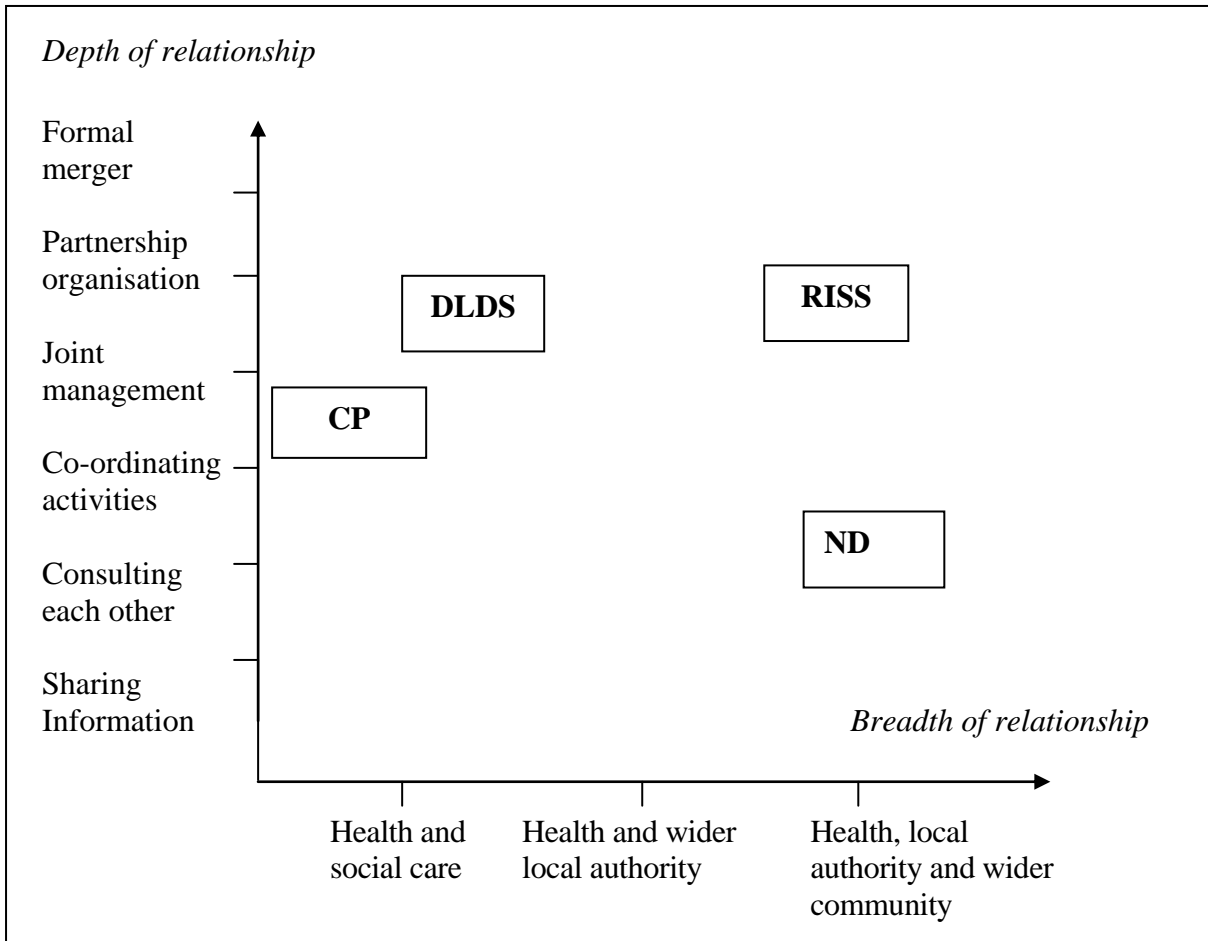
'In the last two years – particularly, there is a great emphasis on joint working thereby reducing the divide between the medical and social care model of disability. The joint working emphasis is based on the principles and mechanisms underlying the Valuing People and as Health Team Manager that I was, we developed protocols for assessments of needs, joint strategic objectives relating to Transition, Dual Diagnosis, Challenging Behaviour, Communication Strategy (including non-verbal systems), Dementia Care pathways/memory clinic. Since the last year we are based together on one site. It has been an interesting journey between two cultures of the health and social care agencies and we still believe we need to make progress to make it right for the final destination – i.e. for better outcomes for people with learning disabilities in [place]!'

This set the pattern that was experienced throughout the research process. Although service users – in this case individuals with learning disabilities – are mentioned, it is simply with the notion that partnership will make “better outcomes”. There is a vaguely aspirational sense that partnerships are capable of improving outcomes and services but nothing more concrete than that.

What these responses ultimately demonstrate is that being involved in evaluative activities is seen as an important activity for local health and social care partnerships. Yet, the drivers to be involved are wider than simply the types of rationalist assumptions that one might initially expect. Responses were not simply received from partnerships that had a clear sense that they were producing better outcomes for their service user populations and wanted to become involved in these evaluations in order to demonstrate this to a wider audience. These were predominantly contacts from individuals who were involved in complex processes of reform within multi-agency settings that were looking for ways in which they could engage and sustain a range of stakeholders in these change activities.

The initial intention in selecting case study sites would be that they would occupy the four extremities of Peck's depth/breadth matrix of partnership working (Figure 4.2) so that coverage of a range of partnerships would be included. Sites would also be selected to provide a mix in terms of client groups and also had to be willing and able to commit time for their staff to take part in the project and appoint an individual who would act as a liaison point for the research. Conversations were held with the sites who made contact following the call over the period of two months in order to short list these thirty proposals according to these criteria. However, in practice the sites did not quite fit as neatly on to the matrix as had intended. As Figure 5.1 illustrates, although there was some variation in numbers of partners involved at each of the case study sites most of the partnerships studied tended towards the more formal in terms of the depth of their relationships. The next sections go on to start mapping the findings at each of the case study sites.

Figure 5.1: Mapping case studies onto the “depth/breadth” matrix



5.3 Rockingborough Integrated Care Service (RISS)

RISS is a multi-agency initiative comprising a number of teams which bring together professionals employed through health, education, social care and Connexions agencies. RISS was set up to incorporate a number of the specialist teams working with children and young adults with special needs and/or disability into a single service (Table 5.1). The RISS plan states that the ‘purpose of bringing these Teams and professionals together is to ensure that their work is co-ordinated effectively and that the support that they provide is based around the needs of the child, young adult and their parents/carers’ (RISS, 2006: p. 3). RISS was set up in spring 2006 and the specialist teams who form the integrated service are based

within the same building (Diamond House) providing a single physical point of public access which is complemented by a single phone number and email address. A number of services are provided on site, but staff also visit children, young adults and their families in their own homes and community settings (e.g. schools and nurseries).

RISS is monitored and reviewed by a Service Management Group which includes parents/carers, local voluntary organisations and senior representatives from the agencies that have staff based within the integrated service. This group then report to the Children and Young People with Difficulties and/or Disabilities Sub-Group within Rockingborough's Children and Young People's Strategic Partnership. It also links to the Learning Disability Partnership Board in relation to its work with young adults with a learning disability. The formally articulated principles which underpin RISS are outlined in Box 5.1.

Box 5.1: RISS principles

- Children and young adults with special needs and /or disability have the right to be supported to participate in family and community activities and facilities.
- Children and young adults have a right to achieve their full potential.
- Services should be organised around the needs of children, young adults and their families.
- Children, young adults and their families are actively involved in all decisions affecting them and in shaping local services.
- Parents need support as carers of a child or young adults with a special need or disability and have a right to a fulfilling life.
- Services will be sensitive to the cultural needs and requirements of children, young adults and their families and will work with them to positively address discrimination.

Table 5.1: Teams that comprise RISS

Team	Agency	Role
Business Support Unit	Education & Children’s Services, Rockingborough MBC & Rockingborough & West Lennington Hospital Trust	To provide business support for all the teams located within the Integrated Service, to be a first point of contact for the public and to lead on building management issues.
Children with Disabilities Team	Education & Children’s Services, Rockingborough MBC	To undertake social care assessment of children and young people with disabilities and their families and provide interventions (including arrangement of support services) to meet identified needs.
Counselling Service	Education & Children’s Services, Rockingborough MBC	To provide counselling for parents and carers of children with disabilities.
Learning Disability Community Nursing & Psychology Service	Rockingborough Mental Health Social Care Trust	To meet the emotional, behavioural and physical health needs of children & young people with a severe learning disability
Early Years Integrated Service Centre Team	Rockingborough & West Lennington Hospital Trust / Rockingborough Primary Care Trust	To provide practical advice, guidance and support for families with pre-school, special needs children.
Early Years Integrated Service Community Team	Education & Children’s Services, Rockingborough MBC	Work with Pre-School children with a statement of educational need and parents/carers/practitioners to ensure quality learning and support. Promoting ‘Inclusion’ of children with SEN and disabilities in mainstream settings
Sensory Support Team	Education & Children’s Services, Rockingborough MBC	To support and meet the needs of hearing and visually impaired children and young people within the borough of Rockingborough along with their families and the schools or settings they attend.
Transition Team	Prospects / Connexions Service Young People’s Service, Rockingborough MBC Education & Children’s Service, Rockingborough MBC Adult Services & Health, Rockingborough MBC	To support young people through their transition from education to post 16 options, including education, employment, training, leisure, housing and support.

5.3.1 How access was negotiated

RISS was the first case study site to experience POET, responding to the call put out through the Integrated Care Network. RISS formally indicated their interest in the process and after a few familiarisation meetings with the team, overviews of the research project and POET were presented to Rockingham Children and Young People's Strategic Partnership Board who consented to RISS being involved in the research.

The RISS service manager was very keen to press ahead with the evaluation at the earliest possible stage. Although the specialist teams who formed RISS had worked together for some time, they had only existed formally as an integrated entity for six months and the service manager was interested in doing some further development work to strengthen this relationship. Thus, RISS was keen to become involved with field testing POET partly because it would provide support to the integrated team who were still in a relatively early stage of their development and additionally because they might gain attention through being recognised as a site of good practice. The service manager felt they were an effective integrated arrangement and were seeking an independent body to essentially confirm and document this.

5.3.2 The process of research

POET was launched locally by holding a workshop to which all those working in the integrated team were invited to attend. This was well attended, forming part of a developmental day for the integrated service. The workshop explained the purpose of the

process and what would happen next. Following the event all staff members were invited by email to complete the first phase of POET. A written report was produced for RISS presenting back the “process-based” findings derived from the completion of the online survey and these were also verbally presented to the integrated team at another workshop to check interpretations of these findings. At this event the outcomes articulated through the survey were also presented and the participants were asked to take part in a group exercise which had been devised to discuss these outcomes further and to ultimately aim to produce a more concise and applicable list than the wide array that had originally been outlined.

After this workshop a postal questionnaire was devised and sent out to all families who had been in recent contact with RISS (as identified by the research liaison). The questions within this survey were informed by the findings of the first phase where staff had suggested the integrated service was ultimately set up to achieve in terms of outcomes for service users and carers and what was perceived to be achieved in practice. The intention of this process was to obtain a broad overview of the perceptions of families and children who had been in contact with RISS and check whether their comments concurred with those opinions expressed through the online survey.

5.3.3 Headline messages from the research process

A high percentage of staff engaged with the research process, with 69% of those invited to complete the online survey doing so. Of these responses, the overwhelming majority of these (78%) were from individuals employed by Rockingham MBC, which is a reflection of the make-up of the integrated service. The overall perceptions reported by those working within the integrated team were largely positive. All the elements of “effective” partnership

working as set out in the literature were reported to be present; although respondents did highlight that the integrated service is still at a relatively early stage and therefore still developing in a number of ways (e.g. developing an integrated culture). Some problems were raised in relation to the status of staff from some partner organisations (particularly those employed by health care organisations) and negative attitudes manifest towards administrative staff. However, the experience of working within the team was reported to be broadly positive.

In terms of staff perception of children and families and their experiences when accessing services, there were clear messages that respondents believe they receive appropriate, comprehensive and respectful services and that by being integrated children and families receive better services. However, identifying specific outcomes was a task which some respondents struggled with. Although there was a general sense that being an integrated service was important (indeed some respondents expressed the opinion that there should be *more* integrated working), there was little more specificity as to what they were trying to achieve in terms of service user outcomes by being integrated. A broad set out of aspirations were articulated, but it was often unclear how these related specifically to being an integrated service.

At the workshop where the findings of the survey were presented back to the integrated service, the long list of aspirations set out in Table 5.2 were consolidated into the list set out in Box 5.2. Although this is a much shorter list, the degree to which these are actually outcomes (let alone service user outcomes) is still limited. Even in this wider discussion the group struggled in thinking about outcomes specifically in relation to the integrated service.

Table 5.2: Outcomes RISS is aiming to achieve, suggested by responses to online survey

Outcome	Rationale
Key working / single point of referral	Families have one keyworker to contact, and services to exist around child. Need to ensure that these are trained properly and whole organisation knows what is expected of these individuals
Greater inter-agency working	Have a better understanding of what other teams do and how that interacts with what RISS offer
Service user involvement	Need to come up with ways of involving families and children in decisions of RISS – for both strategic decisions and care planning.
Regular RISS meetings	Will improve communication between RISS staff
Parent-held records	If these were piloted and established this would give parents more control.
Central referral system	Centralise referrals so go to correct services, and also work more efficiently.
Develop partnership with community	Raise awareness of community about children with disabilities and any issues they may face.
Create an integrated IT system	Would enable better information sharing between teams and organisations in the area.
Work with adult services better	Closer working with adult services would result in easier transition for children to adult service progression
Families being aware of services available	Families knowing what is available to them, give a range of options and choice – perhaps through single point
Empower parents	Provision of support groups would help up skill and empower parents
Empower Asian / ethnic minority parents to participate in partnership with RISS	Asian families not currently perceived as engaging with RISS, but thought this might empower minority parents.
Common assessment framework	Incorporate CAF into ways of working, so all users have same assessment process.
Better health and safety	Staff at risk – particularly lone workers, but also recognise risks for families
Joint assessments	Will make assessment process more effective
Improve starting school experience	More support for children starting school (information, choice etc) would improve this experience
Increase user choice	Better relationships with other organisations and more awareness of RISS in the community would allow to offer more user choice
Access issues – families not often able to find building	Would be easier for parents to find and use – facilitate more engagement
Family friendly paperwork	Introduce paperwork that families can understand – will make services more accessible
Better support for CYP with mild/moderate difficulties	These CYP do not currently get sufficient support from RISS
Resource area for children and families	Will allow people to come in and possibly use ICT resources to find about what is available in the area.

Set targets for families	Formal target setting for families would help families to work towards specific aims in everyday life.
Improved customer services	So families will be able to access services more easily
Improve parking	Make parking more accessible for visitors and staff members
Improve team dynamics	By understanding what everybody does within RISS and having better communication this will improve team dynamics, which should lead to better atmosphere which will rub off on families.
Improved CPD for staff	Better professional development for staff will lead to better services for users.
Improved transportation to Crystal House	Would make more accessible for children and families.
Recording unmet need	Keep a record of the unmet needs of children and families and try negotiate with partners to get these needs met.
Regular RISS meetings	Will improve communication between RISS staff
Central referral system	Centralise referrals so go to correct services, and also work more efficiently.
Resourcing appropriate	Will be able to make better uses of resources
Co-location	Enable closer work.

Box 5.2: Outcomes agreed on by RISS after workshop

Being treated with kindness and care Easy access on the telephone A welcoming building Services responding quickly Information only being passed to other service with our agreement Being able to tell our story once and not repeat it Knowing how to get help from other services Being asked about changes in Services Having the support we will get written down for us Being given the option of home visits Having one professional to co-ordinate our support
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Having gained feedback about the aspirations for RISS in terms of service user outcomes via the online survey and subsequently at a staff workshop, the next step of the POET process involved “testing” these outcomes with children and families. The postal questionnaire was sent out to all families who had been in recent contact with RISS garnered a response rate of 10% (n=52), which, although relatively low, is comparable to rates of return in other research projects when unsolicited postal questionnaires have been used (Oppenheim, 1992).

This questionnaire comprised three substantive sections covering the experiences of families in terms of: the support they received from RISS; which of the outcomes identified through the online survey families valued and would prioritise in terms of the services they receive; and, perceptions of any barriers that they have faced when trying to access services. The questionnaires returned indicated that these families had been in contact with the full range of teams which sit within the integrated service and in broadly similar proportions to the contacts which the service makes in practice. In other words, responses were characteristic of the services accessed and not biased towards any particular specialist team.

Much as staff were largely positive in terms of the types of services provided, the families who responded to the postal survey were also positive in relation to a range of areas. In the free text responses some respondents concurred with the comments made by the integrated service regarding the length of time it took for the team to “get going”, but suggested that now it had been operational for a while it was working much better. At the end of the attitudinal statements families were asked for any other comments they had about the support they are receiving and most confirmed that families are happy with the services they receive. A positive highlighted by a number of those who responded was the role of the key-worker relationship. For example, one family wrote - *“Our key-worker is very supportive to our family - I can't fault her”*. Given the low return rate, extreme results of one form or another might be expected – as respondents might only go to the effort of completing the survey if they felt very strongly. There were no damning responses and the only negative comments were in relation to respite or other services which fall outside the remit of the integrated service.

The questionnaire contained a section which presented the outcomes which were identified through the staff survey (Box 5.2) and asked families whether they agreed that they were important from their perspective in terms of what services they wished to see delivered. The responses were overwhelmingly positive in relation to all the outcomes. To some degree this could be expected though given that many of the statements are probably quite difficult to disagree with (such as wishing to be treated with kindness and care). Moreover, these are quite generalised and aspirational outcomes as opposed to more tangible ones which are clearly linked to inter-agency working.

Families were also asked about factors inhibiting their access to services and this was the section which garnered most mixed responses. The barriers included in this section were the ones which the integrated service staff had suggested caused most difficulty for families in accessing services. Yet, those which families found least important were those which the integrated team had stated were most important to families (for example, accessing Diamond House). Overall the family perspectives were largely positive. However, this is a relatively small sample of families who responded to this survey and a number of the statements were probably quite difficult to disagree with.

5.4 Drumston Learning Disability Service (DLDS)

In comparison to RISS, DLDS have a much longer history in terms of the formal integration of their services. The 2000 inspection of learning disability (LD) services in Drumston had rated these as “*poor*” and with “*no prospects*” and there was a general sense locally that action had to be taken in order to improve these services. The *Valuing People* White Paper (Secretary of State for Health, 2001b) strongly suggested that partnership working between agencies is of crucial success in terms of services for people with learning disabilities and locally it was decided that the most appropriate way forward would be to set up an integrated service. Full use was made of the Health Act flexibilities setting up a pooled budget between Drumston MBC and Drumston PCT and establishing the local authority as the lead commissioner.

Single agency management arrangements were also set up including: integrated community health services with assessment and care management; an in-house social care provider; and, a PCT provider service. The changes leading to integration were described by the executive

team as being brought in “gently”, rather than all at once. A Section 31 agreement put in place in early 2002, but the PCT budget remaining separate to the local authority funds. Single management arrangements were also put in place in 2002, but until 2004 these operated rather informally. All in all, the integrated service took three years to fully implement.

The head of the learning disabilities service is a joint appointment across the local authority and tPCT. The integrated service itself is composed of four divisions (integrated community team, direct provision social care, direct provision health and commissioning), with a Partnership Executive Group which oversees the services. At the time of the research approximately 600 people were employed within this partnership, with a turnover of around £30 million annually. Overall there were at any time between 700 and 900 people supported locally within the community. The Learning Disability Partnership Board is overseen by the Health and Social Care Partnership Board which sits below Drumston Borough Strategic Partnership. The vision, mission and strategic objectives of DLDS are set out in Box 5.3.

Box 5.3: Vision, mission and objectives of DLDS

Our Vision

To make a positive difference to the lives of Drumston People

Our mission

We work with partners to ensure people receive high quality efficient services. These services promote independence and safety, respecting the dignity and diversity of users.

Our strategic objectives:

- To maximise health and well-being and life chances by reducing inequalities and promoting independence;
- To ensure safety and protection;
- To deliver accessible services that are socially inclusive and responsive to user views;

- To become an excellent employer;
- To deliver more efficient business and practice processes.

(Drumston Council, 2006: p. 2)

5.4.1 How access was negotiated

The head of the service responded to the call put out asking for volunteer case study sites and a meeting was arranged to discuss the possibility of DLDS being involved the research. At this meeting the head of service described the genealogy of the services and how since formal integration subsequent inspections had revealed improvements in the quality and performance of the learning disability services. The integrated services had in recent years gained a number of accolades: they been commended in the *Local Government Chronicle Awards* in March 2004 for Social Services Team of the Year; had won the Partnership Award in Drumston; sat in the top 30% of services nationally for ‘Helped to Live at Home’ performance; in 2006 the Links to Work scheme won two awards for improving the environment; and, they had won a Mayors Civic Award.

By late 2006 the service head felt that the integrated services had matured and overcome a number of tensions which had posed difficulties early on (particularly in relation to health employed staff feeling that the integrated team signalled a “take over by social services” and the different terms and conditions of staff within the integrated services). Early on, given the structural, budgetary and managerial changes that had taken place, partnership working had remained a key topic and much attention was afforded to the notion of integration. However, by late 2006, these changes had been embedded for some time and were no longer as “controversial” as they had initially been.

The head of service felt that although there had been many improvements as a result of integration, the team did not have any “formal” evidence which demonstrated that these improvements were due specifically to the process of integration. Although there had been a range of improvements in the formal assessments of the LD services, this had not been independently evaluated as being produced as a result of the formal integration. Locally there was a perception that “partnership had been achieved” given the formal structural arrangements that underpinned the services. Being involved in an evaluation was described by the head of service as a way to “regain local focus on integration”.

5.4.2 The research process

An overview of POET was launched with staff at a workshop which was held at one of the venues where some of the integrated services were housed. This event attracted about 30 attendees, which is a relatively small proportion of the entire number who work within the integrated service. The resources used at the session were made available to those who were not able to attend and a short written document produced which explained the purpose of the evaluation which was sent out along with the invitation to complete the survey.

In the process of negotiating access to each of the case study sites a minimum response rate was agreed upon that would be necessary to make inferences about the nature of that partnership and embark on the second phase of the research process. This varied between case study sites and was related to the numbers invited to complete the survey and also the overall size of the partnership. Given the large number of staff who worked with the integrated services and were invited to complete the survey the threshold for completion was

set at 30% before the second phase of the research could be embarked upon (180 responses). Despite several reminders and the contact at the site trying to engage staff members in this process it proved difficult to engage staff in this process and the response rate reached just 18%.

The staff within the integrated service seemed largely ambivalent in terms of efforts to engage them within the research process. The service head viewed this as emblematic of the difficulties he had had in sustaining interest in the notion of integration locally. He used the lack of engagement to make this point locally and to try and engage staff in further processes of reform which he had wanted to introduce. However, as will be illustrated in the next section, this lack of engagement was not necessarily a negative reaction as interpreted by the service head, but perhaps an illustration that professionals were working together and partnership working was not the “controversial” issue that it had once been in these learning disability services.

The researcher approached the service head with plans for the second phase of research which would do more exploratory work with staff through focus groups and interviews but unfortunately this was not agreed upon. Whilst this first stage was progressing, the national profile of LD services was raised through events such as investigations into abuse in Cornwall and Sutton and Merton (discussed in more detail in chapter six). The head of service suggested that they would no longer be able to participate in the research as all of the integrated team needed to make sure that their attentions were focused on making sure that local LD services were up to par and did not attract the type of attention that other LD services were nationally.

5.4.3 *Headlines from the research*

Those who did respond to the online survey were exceptionally positive about working within an integrated service. Without further investigation, it is difficult to say whether those who responded did so because they are advocates of integrated working and those who would be less positive chose simply not to complete the survey. Although issues of tension were raised these were not necessarily related to the fact that it is an integrated team. For example, there was some dissatisfaction over workloads, the amount of resources available, the amount of paperwork that professionals had to complete and a lack of parking spaces – but these issues are arguably rife across most health and social care communities. The only significant issues that were raised specifically in relation to being an integrated team was having to work across multiple sites which meant that some team members found themselves travelling frequently during their daily role.

Positive comments related to the everyday exposure which professionals had to different groups of people: *‘the chance to communicate with people from very differing backgrounds to include service users, carers and other professionals’*. Others professed to enjoy the contact which they have with service users and the chance this offers to make a difference: *‘I am able to see the impact my role contributes to improving the quality of life for people with a learning disability’*. Another respondent suggested that being an integrated team is hugely beneficial for all: *‘I feel that working in partnership with health at an operational level enables service users to access the services they need quickly and seamlessly which gives me greater job satisfaction and makes my role easier’*.

Throughout the responses there is continual reference to the fact that the integrated team is judged to operate well because of the length of time it has had to “bed in”. Respondents alluded to the fact that there had been tensions before, but these had largely been overcome given the partners’ history in working together. Although the service head had interpreted a lack of engagement in this process as an indication that the team were no longer interested in integration, the responses of those who completed the online survey suggested that integration was no longer an issue as it was no longer controversial on the ground. This was an accepted way of working which had been established for some time.

Table 5.3 sets out the outcomes which were articulated through the online survey. The vast majority of these are very organisationally driven (e.g. single assessment point, care pathway improvement) and refer little to the types of outcomes which the integrated service is specifically trying to deliver for service users and which is different from the ways in which services have traditionally been delivered. Beyond a sense that being integrated was somehow “better”, respondents found it difficult to say why this was so: *‘being integrated helps me feel valued for the job I do and provides better outcomes for the service user’*.

Table 5.3 DLDS outcomes suggested through online survey

Outcome	Rationale
Provide a transition service	To ensure all young people who meet LD criteria receive an effective and supportive transition to adult services
Information sharing across partnership	Enable professionals / service users/families to have readily available and current information
Training for service delivery- physiotherapy	Improve one to one treatment techniques
To increase number of carers approved by 16 over the next year.	More carers and from more diverse backgrounds
Residential reprovision of long stay accommodation	Ensure appropriate housing support options based on person centred approaches
Health Action Planning	To have issued Health Action Plans to all service users who want one within the service and receive a good response from health professionals.
Modernising day services	Close existing day services and provide more appropriate day services at smaller community venues. Provide more meaningful daytime activities
Ensure service users have control over their own life choices	Person centred planning for people whose services are being reprovided
More meaningful user involvement.	Strategy based clearly on local and specific need
Equality of access to all appropriate health services for those with a LD	People with LD have access to all healthcare
Information leaflets	Improved communication
Greater accessibility for people from minority community groups	Currently limited use of services by people from minority ethnic communities
Recruit and retain an experienced and skilful workforce	Ensure vacancies are filled quickly and appropriately
All people who use the service to go through the same processes	All forms and processes to be put firmly in place in the way of a service user pack
To increase uptake of cervical screening by women with a learning disability	Educate, inform and support ladies to go through the cervical screening process and increase uptake by 20%

Better support for carers	increased carers assessments, home based support services etc
Service users consultations	A service that allow individuals to participate fully in the development of learning disability services
Single access points and trust between services to enable better pathways	Forums for all partners including the acute sector, particularly discharge liaison.
To plan and implement a purposeful, appropriate service for our adults with Downs Syndrome	To project the potential number of adults with Down's Syndrome and dementia in Drumston and offer a service tailored directly for their needs.
Person Centred thinking as a integral part of the service	All service users have a person centred plan, whatever its individual design
Development of Step Down Facility	Reduce the number of out of borough placements
Welfare benefit take up (disability benefits)	To give service users the opportunity to choose who cares for them
To increase uptake to breast screening by women with a learning disability	Educate, inform and support ladies to go through the breast screening process and increase uptake figures by 50%.
Single assessment process	Every professional using the same referral process
Appropriate staffing levels so that the needs of users can be properly addressed.	More effective care planning, easier access to services.
Direct Payments	To encourage people to choose what they want to pay for.

5.5 The Children's Partnership (CP)

CP was launched in April 2003 principally as a relationship between Lower Easingham Hospital (LEH), South Hemly Hospital (SHUH), Beddington Teaching PCT (BtPCT) and the Fenningham Hospital. The CP covers the north-central area of a major city with the formal rationale for this arrangement being that, 'the current fragmented and uncoordinated approach to children's health in North Central [place] is not always organised in the best interests of those we serve' (taken from the children's partnership website).

The development of the CP took place within a context where the *National Service Framework for Children* (Department of Health, 2003) and guidance following the Laming Report (2003) and the Bristol Enquiry (Secretary of State for Health, 2001a) were still being strongly felt. The CP was developed ostensibly as a managed clinical network in response to this context, aiming to integrate and organise services around the needs of children and families, rather than being constrained by organisational or professional boundaries. The CP's mission statement is set out in Box 5.4.

Box 5.4: The CP mission statement

The partnership's vision supports the delivery of the Children's National Service Framework (NSF) and *Every Child Matters*:

- To provide innovative, integrated, high-quality services for children and young people by working together;
- to deliver these services as close to home as possible, through sharing the combined expertise and resources available; and,
- to work to a child focused ethos, enabling new ways of service delivery through working together within a managed children's health network.

From the strategy document of the Children's Partnership

The Partnership Management Board comprises Executive Directors from LEH and Host Trusts. A director of partnership development reports to this board, overseeing the various partnership development managers. Partnership clinical unit leads and managers oversee the CP and are accountable to the Trust management boards. From the outset LEH was appointed as the clinical lead and has assumed a lead partner role, ostensibly because LEH is the one partner providing a service focused solely on children, young people and their families. Although the CP covers four different partner organisations, much of the initial action that took place was between SHUH and LEH and this forms the principle component of this evaluation. After setting up the initial governance arrangements for the overall partnership, the first action that the CP undertook was to transfer the management of SHUH paediatric services and staff into the management of LEH. This made LEH responsible for the staff and services based at SHUH, although the paediatric services are still delivered at the SHUH site.

5.5.1 How access was negotiated

In spring of 2006, Lower Easingham Hospital put out a national tender for research to explore the outcomes that CP had produced for children and their carers and to undertake an analysis of the benefits and costs of these arrangements. This sort of partnership arrangement is still relatively unique in terms of children's services with an arrangement between a tertiary care centre and a particular department of an acute trust (in addition to the PCTs who are also peripherally involved in this working relationship) although paediatric managed clinical networks are becoming more common (e.g. Cropper *et al.*, 2002). This arrangement took place against a background of increasing interest in how specialist children's services might

be more effectively commissioned across region and this has particular resonance in this case given the number of specialist units that exist in this city.

The Health Services Management Centre bid for this work, proposing an approach which would essentially incorporate the exploratory case study process using POET as the central tool of data collection. This process would be supplemented by the involvement of a health economist colleague who would work on a cost benefit analysis. The CP wanted to assess the early impact which it had produced for children and families through transferring the responsibility of staff from SHUH to LEH. HSMC was successful in winning the tender for this work and the CP consented to this service evaluation being used as a form of secondary analysis for this thesis.

5.5.2 Process of research

As with the previous two case study sites, a launch workshop was organised and an overview of the programme of research and an introduction to the POET survey was presented to representatives from across the partnership. At this stage, all staff members from the partnership were invited to complete the online survey, 53 individuals completed the survey which is a response rate of 50%. In simple numbers, those based at LEH provided the majority of responses, 66% compared to 28% from SHUH and 6% from BtPCT. In terms of percentage of the total workforce per site, more individuals based at SHUH were invited to take part in the evaluation, yet the bulk of the responses gained were from individuals based within LEH. However, this picture was perhaps more nuanced than these figures suggest as

there was some confusion by clinical staff that were based at SHUH as to whether they were LEH or SHUH employees given the changes to their line management due to the partnership.

Following the completion of the survey another workshop was held in November 2007 where findings were reported back to the partnership. Phase one of this research revealed a high level of confusion and conflicting opinion in terms of the outcomes that the partnership was ultimately aiming to achieve. Moreover, there was a high level of dissatisfaction expressed by those working at the SHUH site. Consequently, phase two of the research could not take place in the way originally envisaged and it was agreed with the CP that more work would be done to try and set out an agreed outcomes framework. At this point it was agreed with the partnership executive that an evaluation might not be the most appropriate course of action to undertake and an intervention in organisational development would probably be more fruitful for the partnership at this stage in its development. Given the difficulties experienced at the outset it was felt that an outcomes evaluation might not be entirely positive given the lack of clarity over specific outcomes that the CP was trying to achieve and also the significant HR and finance problems which had not yet been resolved.

Focus groups were undertaken at both partner sites with clinical staff and semi-structured telephone interviews were conducted with executive members of the partnership to further investigate issues relating the lived experience of the partnership and what it was ultimately trying to achieve in terms of service user outcomes. Around 30 members of the CP, LEH and SHUH staff were directly involved in this second phase and participants were chosen to reflect a cross-section of the partnership including; members of different professions, people at different levels within the partnership and a mix of clinical and non-clinical services. The

findings of this process were fed back in a workshop where a final outcomes framework was agreed upon.

5.5.3 Key messages from the research

The responses to the online survey were not entirely positive in terms of various aspects of the roles of individuals and the way in which the partnership had developed. The reported difficulties were more prevalent at the SHUH site or were primarily experienced by those who worked across the two sites. The responses acknowledged that the partnership was at quite an early stage in terms of establishing processes and communicating its intentions to the staff members involved. A number of respondents suggested they were unclear as to the purposes of the partnership and those who were working at the NHUM site felt that their organisation generally was unaware of what the partnership was and why it had been set up. There was a general perception that beyond LEH, other partner organisations felt little ownership over the CP.

Box 5.5 sets out the key themes reported by the online survey. As this Box illustrates, respondents often found it difficult to outline exactly the CP was attempting to achieve (and particularly those outcomes that should result for people who use services). As Table 5.3 illustrates, where outcomes were identified they were often more related to organisational outcomes than specifically to service user outcomes – although this could be a reflection of the early stage of development which the service was at.

Box 5.5: Key themes relating to the CP reported in online survey

- Staff felt that the CP had the potential to deliver significant improvements in children's services and demonstrated real commitment to the partnership.
- Although partnership working can be a time-consuming process, many people felt that the CP was beginning to overcome initial practical difficulties and really starting to acquire a sense of momentum.
- Despite optimism for the future, many people were unable to articulate clearly what it was the partnership had been set up to achieve, and how this differed or improved upon what individual partners might be able to achieve by themselves.
- In spite of a sense that things were improving in a number of key areas, staff were keen to be able to evidence this – particularly when thinking about how best to develop the partnership and about how best to work with other partners in future.
- There were concerns about the role of individual partners, with some feeling that LEH was (inappropriately) dominating the relationship, and others feeling that LEH was taking an (appropriate) role as a lead partner. Either way, there remained concern that a shared vision and joint ownership would be difficult to achieve without greater clarity over desired outcomes.
- As with any partnership, many staff felt that additional work was required with regards to organisational and professional culture, and to communicate the role and nature of the partnership (both internally and externally).

Table 5.4: Outcomes identified through CP online survey

“Organisational” outcomes	Service user outcomes
Pathway development	Reduce unnecessary admissions
Clinical governance	Reduce travel to hospital
Improved information flows	Faster care
More accurate finance information	Integrating service users into decision-making
Appropriate staffing levels	Reduced length of stay
Better understanding of discharge protocols	See children in appropriate settings by people with right skills (e.g. children’s A&E)
Widen partnership working to include Local Authorities	Improve health of children in the city
Better clinical incidence reporting	Increased choice
Improve quality of services at LEH	Reduce inequalities in health
More interpreters	Reduction of risk of serious harm to children
Staff training and development	Improve communication between staff and users (through use of more specially trained interpreters)
Sharing clinical skills	
More nurses in in-patient ward	
Share good practice	
Teambuilding	
“Sort out services at St Fred’s hospital”	
Reduce repeated tests	
Introduce a common assessment framework	

From the second phase of the research, where more in-depth investigation was done through focus groups and semi-structured interviews, a series of issues were highlighted by participants. Although senior commitment and vision helped to give the CP significant early impetus, it appeared that joint ownership was not necessarily replicated at all levels of the partnership. There had been a focus on an overall vision and a commitment to joint working, prior to working through the practical details of such an arrangement. Many participants at all levels felt that more recent work had been necessary to establish greater clarity about more detailed financial and accountability arrangements. In the words of one participant, the

partnership had been forces to work hard to play ‘catch-up’, ensuring that agreements about the boundaries of the partnership and respective roles and responsibilities were as developed as the overall vision for the CP. For many people, this process was still ongoing, with a need for further work to fully agree practical arrangements. Similarly, many participants felt that there had been more agreement about the overall desire to work together than about the specific outcomes that the CP was designed to achieve. For many people, it was this initial and ongoing lack of consensus about outcomes which had made it so difficult to take part in the evaluation.

Some participants pointed out that the name of the partnership (the Children’s Partnership) had initially been a helpful way of bringing staff together and exploring ways of developing more effective joint working, but no longer fully captured the essential features of the partnership. Essentially, the CP is not a “partnership” at all, but a directly managed service – and participants felt that a title which more fully reflected the nature of this relationship would be helpful. Many participants felt that the CP had developed to such an extent that LEH may require a new organisational structure to ensure that such services benefit from clearly identifiable, visible and more autonomous leadership (both executive, clinical and operational). Essentially, this represented a desire for a new ‘Local and Community Services’ directorate to take forward such new services and partnerships. Crucially, many LEH participants felt that many of the issues raised by this study were more to do with broader questions about the current and future role of a specialist tertiary centre in city like the one where the partnership is based (that is, that current themes and findings were part of a more fundamental question about the future of children’s services and about the future role of LEH). Underlying all these issues was recognition of the need to communicate any changes and future developments as comprehensively as possible (both internally and externally).

Whilst it was acknowledged that communication is always a challenge, it was felt to be particularly important in a complex partnership setting.

In terms of outcomes, participants expressed an (often very unspecific) desire to see the CP as a means of developing:

- More local and more accessible services.
- More holistic care pathways.
- Better quality services.
- Mutual learning between staff from LEH and staff from SHUH.

In terms of what had been achieved to date, participants pointed to improvements in areas such as:

- Access to training and development.
- Opportunities to develop a broader research agenda.
- The recruitment, retention and rotation of staff.
- Child protection procedures and processes.
- Clinical governance procedures and practices.

There was also disappointment expressed that more had not yet been done to develop locally-based services for the SHUH population (with more joint clinics and a greater focus on outreach to local, deprived communities) and more integrated patient pathways.

Building on these themes, participants proposed two main ways of trying to be clearer about desired outcomes, benchmark current services and explore future success. It was proposed that a key indicator(s) of early success would be the extent to which the CP could ensure that children with complex, ongoing needs experience *one less visit to LEH per year* and, at SHUH, for there to be a *reduction in the numbers of children attending A&E with asthma-related problems*. Although quite crude and simplistic, participants felt that this was a potentially powerful way of capturing broader aspirations about developing more local, accessible services for deprived communities. Closely linked to this was a suggestion that the CP adopt the five outcomes proposed in *Every Child Matters*, using these as an overall framework for developing practical indicators and monitoring overall success. While these would only be proxy measures for partners' wider aspirations, such a framework was felt by many to offer a very child-focused way of understanding and measuring success (see Box 5.6).

Box 5.6: The CP outcomes framework

Every Child Matters outcome	Short-term indicators	Longer-term aspirations
Being healthy	Opportunistic immunisation rates Reduced visits to LEH site for targeted conditions Volume of children accessing paediatric services Appropriate A&E attendance	Reduced mortality rates
Staying safe	Adherence to clinical guidelines Various workforce issues (e.g. recruitment, retention, progression though gateways etc)	Medical error rates Critical incident rates Degree of consistency in prescribing practice
Enjoying and achieving	Number of complaints	Patient satisfaction Number of unplanned days off school due to ill health
Making a positive contribution	Percentage of children and families contributing to ward survey	Children and family fully involved in the partnership
Economic well-being	Number of outreach clinics operated	Fewer avoidable days school missed Less visits to LEH site by SHUH patients

5.6 Newfield (ND)

Newfield borough council has a division known as the Adult and Consumer Care Directorate, which has five main functions:

- Joint commissioning of adult social care and community health services (in partnership with Newfield PCT)
- Provision of social services & *Supporting People* for adults
- Strategic housing (including housing stock renewal, energy efficiency advice to the public and tackling homelessness)

- Ensuring consumer rights (through Environmental Health and Trading Standards)
- Emergency planning / civil resilience

Whilst it had been easier to attract sites for the research who had formalised relationships, it was less easy to find those who broad, but shallow relationships. A senior manager from this division responded to the general call to see if they might be involved. Given the mix of partners which had already been engaged through the case studies this seemed to offer a good opportunity to involve other types of organisations (e.g. Housing, Environmental Health).

The directorate had also been recently recognised as being an area of good practice, receiving a 3 star adult social services rating in December 2006, winning National *Community Care* magazine and *Foundations* awards for the Home Improvement Agency, receiving positive inspections of their services and receiving recognition from CLG and Trading Standards in relation to several of their services. The directorate were therefore interested in becoming involved in the research in order to demonstrate their successes through an independent research process and consolidate this recognition.

On speaking to the Corporate Director in more detail it appeared that there were two small teams within the directorate who met the sampling criteria. One team provided mental health and homelessness services, whilst the other comprised a substance misuse bond scheme. Both teams were relatively small in scale (mental health and homelessness has four full time staff, the substance misuse bond scheme has five full time staff and there are also two full time head of services who are also involved in these arrangements). These teams have limited interaction with each other in the locality so it seemed a good opportunity to investigate their relative experiences within a similar environment.

The narrative around these services were that they had developed in a relatively organic sense; a need had arisen in relation to these very specialised areas and although teams existed to service these particular needs there were no structural or management arrangements in place to “formalise” these teams in a traditional sense. Given the small scale of these teams the decision was taken to involve both of these within the research and that this would also offer the opportunity to investigate the extent to which similar patterns demonstrated themselves within different teams within the same locality.

5.6.1 Research Process

To some extent the process of research at ND developed along a similar trajectory to that in DLDS, but on a rather different scale. Despite senior-level sign up to the research, the launch workshops were sparsely attended with the reason given being that they were small teams and so needed to cover for each other and provide a presence for the service. After the workshops all the members of the teams were invited to participate in completing the survey as they had with the other sites involved in the research. Yet despite a number of reminders and also calls to the head of services and the corporate director, only one of the heads of service actually completed the online survey.

Further conversations with a number of individuals within the locality failed to gain any further buy-in to the research process. Given that the staff seemed unwilling to engage with the research programme, a series of telephone calls were made in order to establish why this was. This process was framed as ultimately being concerned with the applicability and utility of POET and whether this was too difficult to complete or inaccessible in some way.

During these conversations members of the two partnerships repeatedly used terms such as “organic” and “bottom-up” to describe relationships that were built on the basis of “trust” and “longstanding” interactions between a series of specific individuals. These respondents repeatedly stressed their desire for their partnerships to remain small, informal arrangements which operated to some degree “under the radar”. By engaging in a process of evaluation they feared that they would no longer be able to do this. It was feared that the more recognition that they were exposed to locally, the greater the danger that they would be required to “formalise” in a structural sense or would be more open to “top-down” direction. Those working in these partnerships were not negative about the research process and indeed many were interested in the overall programme, but were worried that this might in some way serve to undermine the long-term activities which had gone into making these partnerships a reality.

Some months into the start of the process it became apparent that although the corporate director was interested in these partnerships being involved in the research, the teams themselves were resisting the process. Further conversations were held to try and come to an agreement in terms of a way forward, but without the cooperation of the partnerships this would render any second stage of research impossible to undertake.

5.7 Common themes and experiences across sites

This chapter has so far set out the empirical findings of the research as it was conducted at each of the sites. The main features of each case study and what the process of research uncovered are summarised in Table 5.5. Looking at this table it seems that there are a

number of commonalities amongst three of the case study sites. Rockinborough, Drumston and the Children's Patnership most commonly align in terms of their inability to articulate the types of outcomes that they were trying to achieve for the service users and carers who were accessing their services. Beyond setting out rather aspirational sets of outcomes in various vision documents, when asked to complete the online survey and in subsequent processes, stakeholders were not clear about what it was precisely that their partnership was there to achieve and what success would ultimately look like for that partnership.

Often there was somewhat of a paradox in terms of the responses provided to the online survey component of POET. RISS provides a typical example in this respect. In response to the statement '*the integrated service has clear outcomes for children and families*', 80% of respondents "*agreed*" or "*strongly agreed*". Nobody who completed the survey disagreed with this statement and the remaining 20% indicated that they "*did not know*". At first glance this seems a fairly compelling response in the sense that it might be interpreted from this that RISS has a clear sense of what it is trying to achieve for families and children. Yet, when asked to articulate *what* these service user outcomes are, respondents experienced difficulty in being clear about what these constituted specifically. Neither was the experience at RISS an isolated case, with a similar pattern evident across other sites.

Table 5.5: Key features of the exploratory case studies

Case study site	Features of local context
<i>Rockingborough Integrated Support Services</i>	<ul style="list-style-type: none"> • The various specialised teams had worked together for some time, but the integrated service represented the “formalisation” of this arrangement through structural means. • The publically articulated aim of these arrangements was to better co-ordinate service delivery for children and families. • The evaluation revealed that most staff were positive about the processes of working together within the integrated team. The only contention came from a few professionals who came from health care organisations and felt dislocated from their organisational backgrounds. • High levels of staff involvement in evaluation as it was perceived as a chance to demonstrate local achievements and ownership which staff feel over the integrated team. • Outcomes identified by the integrated team often very “organisational” and here these related to service user outcomes was unclear as was the link to partnership working (e.g. make safer, empower service users, improve environment of Diamond House). • Outcomes identified by staff as being important to service users were different to those deemed important by children and families. • Families identified the role of the keyworker as being crucial to delivering quality services. However, keyworker role existed prior to the establishment of the team and was not directly related to the establishment of the integrated team. The main areas where families identified difficulties fell outside the boundaries of the integrated team. • The team used the evaluation as a way of re-opening negotiations over which professionals should be included within the formally integrated team, or as a way of demonstrating the effectiveness of RISS and why other local services should afford legitimacy and consideration to this relatively small and specialised team.
<i>Drumston Learning Disability Services</i>	<ul style="list-style-type: none"> • Need for formalised partnership working came about following negative inspections and reports about poor quality of services. • Relatively long lead in time to formalised integration which today exists over a large scale. • Formalised integration was initially perceived as quite controversial and remained so for some time whilst significant changes in systems and structures were achieved. • As structural reforms became more embedded, partnership working became less controversial and was not

	<p>something that was as central to local discussions as it had previously been.</p> <ul style="list-style-type: none"> • After structural reform had been put in place processes of further reform and modernisation were perceived to have slowed down. Involvement in the evaluation was seen as a way of revitalising interest in processes of change under the label of “partnership working”. • Staff found it difficult to identify the outcomes that partnership working was designed to achieve. Where outcomes were identified they tended to be organisational in nature and related to issues of structures, finance etc. • Staff not highly engaged with the evaluation as they felt that partnership is no longer a “contentious” issue. Lack of engagement used by head of service to posit a lack of interest over integration locally and call for partners to re-engage over specific service improvement issues. • Involvement in evaluation halted when external events superseded, putting the spotlight back on learning disability services nationally.
<p><i>Children’s Partnership</i></p>	<ul style="list-style-type: none"> • Partnership represented as a way that LEH and SHUH could learn from each other. This agreement would then be widened out to involve local PCTs as a way of better understanding and reacting to the needs of children locally. • LEH assigned the lead partner role from the outset for seemingly pragmatic purposes. • Difficulties in identifying service user outcomes. Many of the outcomes identified very organisational. When pushed further, service user outcomes identified although these were very aspirational in nature and not obviously related to partnership working. • A number of practical difficulties were being experienced by those working at the SHUH site and staff reported feeling dislocated from their wider organisation and badly treated. • Further investigation suggest that LEH involvement in the CP was a means through which LEH could consolidate power and position in terms of future reorganisation of paediatric services in that region. • SHUH’s involvement in the CP perceived as a way of demonstrating that taking notion of improvement seriously by gaining expertise and training from LEH, particularly given previous negative reports about its paediatric services. • Although the CP was very visibly identified as a “partnership” (thereby setting the expectation that this would involve mutual learning for both partners) it was, in practice, an attempt at uni-directional transformation without being explicitly declared as such. • LEH interested in being involved in evaluation as a way of demonstrating their commitment to service improvement as part of a Foundation Trust status application.

	<ul style="list-style-type: none"> • SHUH staff engaged in evaluation as a way of demonstrating on a public platform that they had been misled by the “partnership” and did not feel it was an arrangement between equal partners.
<i>Newfield</i>	<ul style="list-style-type: none"> • Service executive looking for a way to be involved with the programme as a way of demonstrating local effectiveness. • Research programme was seeking case studies that had “broad and shallow” relationships on basis of the depth/breadth matrix and the executive identified two small teams within the Directorate that fitted these characteristics. • Senior executives therefore signed up to the evaluation and told the teams that they wanted them to be involved with these processes. • Despite being instructed to engage, staff resisted involvement in the evaluation. • Multiple attempts to engage the teams in the process but to no avail. • In further discussions with professionals from these teams it became clear that they were unwilling to become involved as this would draw attention to their activities. They described their teams as organic and bottom-up, built on relationships of trust between individuals. Being “on the radar” was thought likely to lead to changes being made or to the formalisation of their teams.

Had the online tool been the only data collection tool employed within these localities to try and access notions of outcomes then this finding may have been questionable to the extent that the process of articulating outcomes is likely to be relatively challenging, at least culturally, to health and social care professionals. However, as the previous chapter demonstrated, multiple methods were used within these case study sites. The issue of accessing outcomes was not necessarily methodological and could therefore be solved by finding the most appropriate means through which these might be articulated. This was a more fundamental issue relating to the local meanings and values attributed to the notion of partnership.

The very fact that multiple case study sites were unable to articulate the outcomes they were aiming to achieve for service users and carers within their local area is a compelling finding in itself given that partnerships have most often been predicated on the notion that they are ultimately aimed at improving service user outcomes. Although various vision statements and official documents were unearthed at these sites that set out the types of outcomes which these entities were (publically at least) set up to achieve, the lived experience of those working within these arrangements was that there was vastly varied opinions about what it was precisely that these entities were meant to achieve in practice. Although all were publically orientated towards service user outcomes and all aimed to provide “better” services to those who accessed them (and their families/carers), there often appeared to be little more specificity than this and therefore the expectations and the lived experience of many of the stakeholders involved was rather different in practice.

All of these three case study sites were undergoing fairly significant processes of change where “partnership” was used as the way of labelling these programmes of change. Various

stakeholders at Drumston described how DLDS had undergone a process of modernisation over the past five years which had commenced when inspectors had identified the poor quality of LD services. In responding to these concerns, Drumston took the decision to form an integrated service that would be responsible for both health and social care aspects of LD services. This option had a high degree of salience at that point in time given the recent publication of *Valuing People* (Secretary of State for Health, 2001b) which strongly recommended forming LD partnerships. In Drumston substantial changes were made to structures, finances, workforce practices and to the range of settings where care was delivered – all under the guise of forming integrated services that would help improve performance. The creation of an integrated service therefore became the primary aim in Drumston. This was achieved over a three year period and DLDS was recognised as having improved in terms of its local performance.

However, once this had been achieved and publically recognised, there was no longer a context of urgency to engage in processes of change. A number of stakeholders stated the opinion that “*partnership had been achieved*”. As there had never been any specific outcomes outlined for the integrated service (beyond some fairly normative statements) then DLDS could never be judged as successful. Partnership, or in the case of DLDS, the integrated service was described by local stakeholders as something that could be “put in place” or “achieved” but with little sense of for what ends. The structures and processes that had caused significant difficulties to work through had been completed and so local stakeholders assumed that this meant that partnership had been achieved. Moreover, local services had improved and this had been recognised in subsequent inspections of the LD services.

DLDS volunteered to be part of the evaluation as a way of re-invigorating staff members around the notion of partnership as the executive team felt that perhaps this had lost some of its momentum in recent months. To some degree this was confirmed through the process of conducting the research. Despite having executive support and middle managers charged locally with facilitating access to computers and encouraging individuals to complete the online survey, staff still largely failed to engage with the process. In feedback workshops and in trying to arrange interviews and focus groups there was a similar experience that staff were not interested in engaging with these types of discussions. In practice this was used by the head of the learning disabilities to demonstrate to his staff members that they were no longer as engaged in the partnership agenda as they had been, and supported his claim that this threatened the future development of strong and appropriate LD services in Drumston.

The intended second research stage did not take place at DLDS, ostensibly due to this insufficient engagement with the first phase of research. Yet, there was a further dimension to this decision. Following the Healthcare Commission and the Commission for Social Care Inspection's (2006) joint investigation into the services provided by Cornwall Learning Disability Trust and the Healthcare Commission's (2007) investigation into the learning disability services provided by Sutton and Merton PCT, there were a number of concerns expressed over learning disability services nationally. *Valuing People now* (Department of Health, 2007b) and the NHS operating framework for 2008/09 (Department of Health, 2007a) both make mention of the importance of PCTs taking action in areas where performance is not meeting standards, with an aim that all NHS campus beds for people with learning disabilities should be closed by 31st March 2010.

In January of 2007, DLDS still had five residential units for people with a learning disability (around 50 beds in total) and rated at least two of these as being “high risk” (Joint Head of Learning Disability Services, 2007). Given that LD services had become an issue of concern to the Department of Health and had also gained much attention through the media, this had served to focus attention on learning disability services locally. This attention had re-invigorated local staff to focus on the issue of learning disabilities and this was happening largely “in partnership” given that both the local authority and the tPCT were being heavily performance managed on this issue.

In the case of RISS, an integrated team had been formed in order to deliver services to a relatively niche or specialist area of the local population. There had been some local debate about which professionals would be formally integrated into the team and which would sit outside. The head of service described the resulting organisational settlement as understanding this as a “pragmatic decision” where he had not entered into too much laboured debate in order to gain approval to transfer more health-related staff under the management of RISS, even though he and other members of the integrated team thought there should be a more significant “health” presence within the team. The integrated team and the families and children who accessed these services largely judged these to be a success. Yet when the integrated team were asked what they were attempting to achieve in terms of service user outcomes a number responded “more partnership working” or “more integration”. When this was questioned further these professionals explained that many of the difficulties that the local families and their children faced were in accessing professionals or services that existed outside the boundaries of the integrated team.

More integration or more partnership working was their way of expressing that what was important from their perspective was bringing these professionals within the remit of the integrated team. The integrated team had initially been established not in the “ideal” form that the executive originally had in mind due to the difficulties in persuading partner agencies to transfer their staff into the employment of the team. Although a relatively newly integrated team in some ways, it considered itself to be a well-functioning service and wanted to be seen as a beacon of good practice and have its legitimacy demonstrated through an independent evaluation. The team had only been in place for a relatively short length of time and so was also seeking to get support through the evaluative process which would aid its development.

The children who receive services from this team have profound and complex disabilities and require inputs from a range of different teams from across the local authority, education, health care, housing, transport, third sector organisations and a whole range of other services. The integrated team felt that if they were to be truly “effective” they would need to work with a whole range of different agencies (statutory and non-statutory alike). The role of the keyworker in this setting was to co-ordinate and facilitate access to these different services. Those in keyworker roles described a relatively simple process in terms of accessing services from other colleagues within the integrated team, yet often a rather more difficult one in terms of accessing those that operate outside of these boundaries. Their day-to-day role was actually becoming more difficult as they were being required to interact with a different range of services that they had not been required to deal with in the past. There was an acknowledgement locally that partnership exists on some sort of continuum and that different relationships would be needed with different partner agencies. What this reflected to some extent is the inevitability of boundaries: wherever boundaries were in place in terms of the

integrated team this would inevitably mean that boundaries would exist with other areas of services.

Moreover, there was now an expectation that they *would* do this. There was such an expectation that keyworkers could join up all services that some families were surprised when they encountered areas which did not join up as well as they had expected. In essence, in attempting to address the types of “wicked issues” that children with complex disabilities and their family encounter, RISS had actually marshalled a number of the “tamer” and less controversial services under its control. This was done so on the basis that the organisational settlement would remain under negotiation and if RISS could demonstrate that it was working “effectively” it would be a much simpler process to draw in other professions to the team in future.

The head of service was well aware of the difficulties with which the families accessing his integrated team were faced. There were particular and ongoing issues with access to respite care and also in relation to one of the service providers in particular. Both of these issues were highlighted by the evaluation, at the same time as families were being positive about their experience of receiving services from RISS. Not only had the local service been positively assessed through an independent evaluation, but families and children were expressing an expectation that their services be joined up in a seamless fashion and that this was not always their experience with wider partners. RISS would be seen locally as an example of best practice, but the process of evaluation also gave these services extra legitimacy when attempting to enter into discussions locally either in terms of where it would be appropriate to incorporate other teams into the integrated team or in terms of demanding more attention in terms of their links with other bodies.

The Children's Partnership from the beginning was very deliberately presented to staff, service users and external stakeholders as a "partnership" in the sense that the two organisations were keen to emphasize that each had much to learn from the other, with SHUH benefiting from the expertise, resources and reputation of LEH, and LEH learning from SHUH about the skills and approaches required to work with children with lower-level needs in the community. Yet, during the research it became apparent very quickly that neither LEH nor SHUH felt that this was a true "partnership" and the CP was described by most as a LEH "takeover". Although most of the LEH staff and some of the SHUH managers were content with this, many of the front-line staff at SHUH felt that the CP should be a partnership of equals. The CP had been portrayed as a "partnership" for the benefit of front-line staff and whilst this may have reduced initial dissatisfaction and resistance with some significant changes to organisational arrangements. It arguably came back to haunt senior managers when the lived experience of working within the CP became at odds with what they had originally been promised.

Despite the public aspirations to be a "true" partnership, most staff felt that the way in which the CP had been established and carried out its subsequent work reinforced a sense of a LEH "takeover". Although the partnership spans two sites, most meetings and training took place at LEH and SHUH staff were typically expected to travel. The board established to oversee the partnership was dominated by LEH staff, and the SHUH senior management team were felt to have disowned paediatric services now that responsibilities had been delegated to CP. Moreover, given a leading role for LEH, many participants felt that the procedures, approach and culture adopted by CP were all LEH-dominated. One respondent comment typified this view:

“It’s hard to see where SHUH staff fit within the CP structure. There is too much emphasis on LEH for it to be a true partnership. We could progress things much more effectively if there were a better balance of partners”.

The partnership had been sold on the basis that it would provide mutual transformation of the two partners, but in practice SHUH was being forced to change their organisational culture or objectives to become more similar to those of LEH.

Whilst most of those involved in the research claimed that the CP was set up to improve services for patients, the overwhelming sense from the evaluation was that it was primarily motivated by organisational interests. In the case of the CP, the desire to reduce duplication, simplify systems and save money as a result do seem as appropriate aims, without having to necessarily dress this up in terms of service user outcomes. The formation of the CP was achieved against a backdrop of some very real and ‘hard-headed’ organisational realities. In the wake of the inquiry into children’s services in Bristol (Secretary of State for Health, 2001a) there had begun a series of debates over the most effective way in which specialist children’s services could be commissioned and pathways delivered in a seamless manner.

Given that paediatric tertiary services deal with conditions of low incidence in comparison to adult equivalents and that they tend to be high cost, it is more likely that children will be required to travel for care. Behind the scenes of the formation of the partnership were a series of recommendations which were being made about the need to form managed clinical networks which should link local specialist services with secondary and primary care (e.g. Royal College of Paediatrics and Child Health, 2003; Cropper *et al.*, 2002). This background is important in demonstrating why it is that the CP was so keen to be evaluated. LEH is

aware of its reputation as an internationally renowned specialist paediatric service. It was anticipated that the evaluation would lead to a favourable report about the arrangements that had been put in place and this would cement LEH's reputation even further. Moreover, in terms of their position in the London area this would be crucial going into the future given the relatively large number of specialist centres that the capital houses. At the time of commissioning the evaluation, LEH was also preparing its application for Foundation Trust status. In terms of this process of application the board understood that independent evaluations which could demonstrate the impact of local services were broadly favoured and it was felt that this process would be helpful in contributing to this process.

The LEH executive saw a need not only to get on the front foot in terms of these organisational processes, but also to find to cultivate a position of strength from which to take part in discussions about the organisation of paediatrics services over the city. Although they have a good reputation for tertiary paediatric services nationally and internationally, given that they are such a specialist service provider they are, in terms of scale at least, a relatively small player in terms of the provision of children's services. By essentially franchising SHUH's paediatrics services, the LEH brand moved into the more generalist area of provision of children's services and was thus afforded a greater role within this area.

SHUH seemed an ideal partner given the difficulties which they had experienced locally. Victoria Climbié had attended SHUH on more than one occasion before her death and the hospital had been substantially criticised in subsequent investigations into her death. Paediatric services are a small proportion of the activities of this hospital and perceptions were that the likelihood was these services would no longer be provided in the future because of the negative findings and concerns over their quality. Given this context, the ability for

SHUH to tap into the specialist knowledge and brand of LEH, whilst at the same time LEH demonstrating its willingness to operate outside of a narrow area of service provision seemed like a win-win situation to the executives of both organisations.

However, these motivations were not publically acknowledged. In the short-term this avoided some difficult initial conversations with staff and service users. SHUH staff stated that they would not have agreed to the “take-over” arrangement which the CP ended up proving to be. They had, however, agreed to a “partnership” where both learned from each other. What this ultimately meant was that when the resulting “partnership” was at odds with what staff initially envisaged they felt that either the partnership had failed to be appropriately implemented or that they had been in some way duped into this relationship.

As outlined above, the process of encouraging staff to articulate the types of outcomes they were ultimately aiming to achieve proved rather difficult in practice. When pressed, individuals tended to become rather preoccupied with organisational issues, as opposed to the interests of service users. The issues which hindered the “processes of partnership working” on a daily basis for these individuals related to a *“lack of an integrated management system”* or *“IT systems that don’t talk to each other”*. Therefore, what they wished to see achieved was the resolution of these issues and a number of stakeholders were involved in projects to overcome these complexities. Although those working within RISS were generally happier with the working arrangements than some within the CP, there were interesting patterns in the types of service user outcomes that they suggested. A number of the issues that staff raised through the online survey as causing problems in their everyday roles linked to the physical environment, including: problems relating to parking at Diamond House; difficulties in finding areas to store equipment and paperwork, and; concerns that the building was too

noisy at times. When asked about what outcomes the integrated service should be achieving for service users, a number stressed that in addition to providing a single access point this should also improve the environment of the building. However, these were considered some of the least areas of importance from the perspective of the families who were involved in the research.

Families stressed that they were acutely aware of the lack of resources available for these types of services and would prefer to see available funds put into additional service provision as opposed to making the building more “welcoming”. Most families received services not at Diamond House but at their own homes, at schools or nurseries and so they were infrequently required to visit this location. Further, many reported that even if they did they did not actually own a car and so parking was not an issue. Therefore, given the keyworker role, families actually made limited visits to Diamond House and therefore the quality of the building’s environment and the ability to park was much less of a concern to them than to staff members. There is significant dissonance between what families considered to be important and what the professionals working in these settings assumed that families wanted to get from the partnership. As there is little specificity either nationally or locally then it is not, to some extent, surprising that staff were unable to articulate service user preferences. The existence of these information gaps enabled staff to employ the language of service user outcomes to frame issues which were primarily of concern to themselves. In other words, in the absence of explicit statements of partnership aims, the language of ‘service user outcomes’ was appropriated in the pursuit of improvements to staff working conditions.

What was clear from the research conducted with children and families was the importance of the keyworker role and how important these individuals were in co-ordinating the types of

services that families want and need. Indeed, many of the respondents from the integrated team pointed to the keyworker role as illustrative of the fact that the integrated team was effective. Yet, a keyworker role had existed prior to the establishment of the integrated team and existed in analogous services in other areas despite not being formally integrated. What appeared important to families was the keyworker as an individual and not necessarily the fact that they are supported by an integrated team. Relatively few families knew either the name of the integrated team – or even that it was integrated. Given the single point of access, it tended to be known by its location. For example:

*'I think **Diamond Drive** have been brilliant, they really have. Even from day one, even though it was a bit overwhelming having them sort of coming in and telling me what to do with [Name]. It was great, the knowledge for me to be doing the right things. I think they've been brilliant and every time – because I know who's going to come, I know them now and there's all these set people, there's nobody new that comes. I've been given the person that does the physio, I've been given the person that does the occupational so they know I don't have to do that with them but whereas the hospitals, there's somebody new that we see every time we go in and repeat yourself'.*

That service users and carers should be more interested in the care that they receive than organisational structures is hardly a new idea. However, it is an interesting point in seeking to draw out potential relationships between service user outcomes and partnership.

The case study which is most different to DLDS, RISS and the CP is Newfield. ND proved to be almost impossible to engage in the process of research. Although it was difficult to engage stakeholders at some of the other sites, they were nevertheless engaged to some degree. One of the issues here may have been that the contact from ND was originally from the head of the directorate, rather than from the partnerships. This contact had got in touch

with the research team as they were interested in engaging with research that would demonstrate that ND has effective local teams which are delivering quality services for local people and to this extent they could garner some attention for the work which they were undertaking. When it became clear the types of characteristics that were being sought for the final case study, this seemed an opportunity for the directorate to showcase some smaller teams and in a way which these quite small but innovative services had grown up in a rather organic way. However, this view was not shared by the members of these teams. These individuals expressed a concern that by being involved in an evaluation they would go from being “under the radar” to having a high profile within the local area.

Some of those working within these two teams felt that they had only been able to achieve what they had done so far by retaining a relatively low local profile and that changing this could potentially be detrimental to their activities. Whereas most of the other sites saw evaluation as a way in which they could influence the expectations of others in terms of the legitimacy of their activities, the teams at ND were less willing to become involved because they did not want wish to draw attention to their services. There was a perception locally that where partnership working was seen as being effective, attempts were often made to formalise and roll out these types of working arrangements to other areas. If the teams drew too much attention to their activities they felt they would have to formalise the accountability structures which were presently not codified in a formal management organisational sense, but instead operated much more under unwritten, trust-based bonds.

This section has briefly provided an account of the commonalities and the differences that were observed within the case study sites. These themes are further developed in the following chapter in reference to the extant literature pertaining to health and social care

partnerships, in order to demonstrate what these sites tell us about the nature of the cultural performance of partnership.

5.8 Chapter summary

This chapter has provided an overview of the case studies, the process through which access was negotiated to these sites and the key messages from the exploratory process of research which was set out in the previous chapter. The characteristics of these sites vary, yet the research experience at these sites was similar in a number of respects: the most significant of these being the inability of a range of stakeholders to identify quite what they were trying to achieve in terms of outcomes for service users and carers.

Although consecutive sites stated that they were clear what it is that the partnership was ultimately set up for, they found it rather more difficult to articulate this with any more specificity than a series of rather ultimately organisational, as opposed to, service user and carer outcomes. Moreover, when pressed in further investigation these often became a very aspirational set of outcomes which varied according to the professional background or stakeholder vantage point that these individuals occupied. Given these observations it became apparent that these partnerships were not ultimately as orientated around the improvement of service user outcomes as they publically claimed to be and that there may be further factors at play that were not being as explicitly articulated. These observations are given further impetus given the range of motivations uncovered for a variety of the stakeholder groups to become involved or to actively resist the research process. This chapter sets the scene for the discussion set out in the following chapter.

Chapter Six: Analysis and discussion

'The concept of partnership has become a corner stone of a range of recent shifts in policy aimed at modernising institutions across the whole field of civil and public life' (NHS Confederation, 2002: p. 3)

6.1 Introduction

This chapter builds on the findings set out in the previous chapter and relates this to extant theories and concepts about the nature of partnership working and organisational behaviour. Ultimately what this chapter argues for is viewing partnership not as a means-ends improvement mechanism, but instead as a cultural performance of governance. Within the case studies explored for this research, partnership is seen to have rhetorical and symbolic value that has been exploited to engage individuals and groups in processes of organisational change which they might otherwise have resisted. However, this is not to suggest that agents operating within these systems are at the whim of controlling leaders and, indeed, there remain opportunities within these processes for individuals to resist processes of organisational change or to shape these around their own specific interests. That is, in understanding partnership as a cultural performance, in the iteration and citation of performances there is room for adaptation of this notion.

Partnership is considered an active tool of governance on the basis that it is used to engage and mobilise individuals, whilst at the same time satisfying external expectations in terms of how these services *should* be structured and what they should be ultimately seen to deliver. This takes the concept of partnership beyond standard discussions of governance in which

attempts are made to determine the mode of governance (i.e. hierarchies/markets/networks) that partnership represents. Partnership may be accommodated in all of these modes of governance; what is important is a more nuanced understanding of the everyday dynamics of the types of organisational contexts that partnerships operate within and how this concept has been engaged to bring about change and/or fulfil expectations of change.

6.2 The power of institutional forces

As the quote from the NHS Confederation set out at the top of this chapter argues, partnership is strongly associated with notions of modernisation. As chapter one illustrated, partnership has indeed been a “cornerstone” of modernising processes associated with the New Labour government. *The NHS Plan* (Secretary of State for Health, 2000a) set out a ten year programme of reform for the NHS and, as previous chapters have illustrated, also suggested significant changes for social service partners with promises such as, ‘the new approach will shatter the old demarcations which have held back staff and slowed down care’ [Para 9.5]. Within this context it was clear that what government wanted was more change and on a significant level. More resources were being channelled into health and social care services than ever before, but government had been clear that transformation needed to go hand-in-hand with this increased investment. As Tony Blair (2000) insisted, ‘a step change in resources must mean a step change in reform’.

Even after ten years of reform, in their 2010 health election manifesto, Prime Minister Gordon Brown (The Labour Party, 2010: p. 3) declared in his foreword to this document, ‘only a decade ago, the very existence of the NHS seemed to be in doubt. Now with sustained investment and reform, the NHS is working for all the people of Britain –

delivering higher quality healthcare which is far easier to access in safer and more convenient settings'. He then goes on to outline the challenges facing the NHS and states that, 'taken together these factors demand radical reform and change across the NHS if we are to meet the aspirations of the public to world-class healthcare. They require an increase in the pace of change'. The Labour party were making a case that the NHS had already modernised extensively from an anachronistic and inefficient monolith, but despite this, what is required in the future is still more change and reform.

At the time of this research then, the mandate for local health and social care communities was clear. They needed to modernise and make a range of changes within their locales to satisfy the national policy context. Further, within this context of change and reform it appears that one of the primary mechanisms through which they might do this is partnership. In policy terms partnership is centre stage and has been for some time. More than a decade ago Pratt *et al* (1998: p. 4) summarised that, 'Partnerships are no longer an optional extra but now take centre stage. The question is not whether partnership is to be adopted, rather how to carry it out'. This has not waned over the intervening, but arguably the drive for partnership has become even more pressing. At a national level one of the main drivers of reform was partnership and there were endless pronouncements from central government that what local health and social care communities needed to do was "more partnership". Partnership appears as the modernisation tool of choice at the local level and one that is difficult to argue against given its "motherhood and apple pie" appeal.

Although some aspects of the modernisation processes might be welcomed, modernisation is not always seen as a positive process by professionals. Change is challenging and threatening, taking people beyond the status quo. Yet, what is intriguing about partnership is

that it appears that this was not regarded as threatening and in a number of cases was actively welcomed by professionals. It is argued here that this is because partnership is an appealing term to health and social care agencies, professionals and service users alike. It is unquestioningly seen as a positive thing and not necessarily a mechanism for getting access to more resources or exerting power over other partner agencies or indeed other constituencies. The efficacy of this term is such that it might appeal to multiple audiences and mobilise them in processes of change and within a context that some modernisation processes are partially implemented at best or resisted at worst.

Given that partnership was adopted within all of the case study sites in conjunction with some forms of change activities, an institutional analysis would suggest that partnership is prevalent within health and social care communities not simply as it is the most rational response to a specific set of challenges faced; but instead as a product of institutional isomorphism. In the analysis of the national policy context set out in chapter three and the exploration of the case studies set out in chapter five, arguably all three forms of DiMaggio and Powell's (1991a) isomorphism can be found within the broad field of health and social care partnership. Central government has produced coercive isomorphism by both explicit techniques (e.g. a legal duty for health and social care agencies to work together) and more subtle techniques (e.g. making partnership a necessary feature for some sources of funding). Through the onus put on interprofessional education throughout the training of health and social care professionals (Carpenter & Dickinson, 2008) and the types of consultants and management experts that have been engaged in local health and social care communities, there is a strong presence of normative isomorphism.

Yet it is arguably in terms of mimetic isomorphism that such an analysis would suggest partnership gains its greatest power. As Abrahamson (1996) argues drawing on neo-institutional theory, management fashions come in to being as they appear to be the most rational way of achieving progress and improvement. Through the way that these techniques are communicated they appear as the most appropriate and suited option to that context. ‘Rhetorics must not only create the belief that the techniques they champion are rational, but also that they are at the forefront of management progress’ (Abrahamson, 1996: p. 168). Rhetoric is a powerful tool in the field of cultural performance, yet in recent years the notion of rhetoric is often considered pejorative, being viewed as a manipulative or superficial way in which to force people into particular courses of action. In this sense it is often seen as an undesirable force which threatens democratic processes and one which is distinct from rational speech:

‘Rational speech, on this view, the speech to which deliberative democracy should be confined, consists of universalistic, dispassionate, culturally and stylistically neutral arguments that focus the mind on their evidence and logical connections, rather than move the heart or engage the imagination...Rhetorical speech, on the other hand, aims not to reach understanding with others, but only to manipulate their thought and feeling in directions that serve the speaker’s own ends’ (Young, 2000: p. 63).

As outlined in chapter two, interpretive perspectives argue that universalistic and dispassionate arguments devoid of cultural influences do not exist. Language is not a neutral medium through which facts and meanings are transparently conveyed. Rhetoric reveals much about the implicit assumptions of a particular group or audience about their attitudes and beliefs. From an organisational perspective, rhetoric may be considered as a spoken and written discourse that justifies the use of a set of techniques for managing organisations or their employees (Barley & Kunda, 1992). Rhetoric is therefore one of a set of linguistic tools

available to perform governance. Rather than being directive and coercive “hard tools” of power, concepts that have rhetorical value might be engaged for their symbolic and cultural value. Returning to Goodwin *et al's* (2004: p. 53) analysis of instrumental and symbolic power set out in chapter two, the value of rhetoric in a performative analysis is in its role in moral suasion. Concepts which have rhetorical value offer a shorthand way of citing and (re)citing particular cultural notions in the processes of performance.

Given the prominent place of partnership within central government policy, it is clear to local organisations that the wider institutional context values partnership and imbues it with importance. Moreover, partnership is unquestioningly positive and is firmly associated with improved service user outcomes. The rhetorical value of partnership offers a powerful tool therefore in terms of mimetic isomorphism. Areas such as Somerset have been widely lauded as examples of best practice in terms of partnership. Yet, as argued in chapter one, the impact of Somerset was deemed by Peck *et al* (2002a) to be primarily in terms of structural innovation, rather than any real demonstrable impact on service user outcomes. Yet, by being named in *The NHS Plan* (Secretary of State for Health, 2000a) this gave the notion of partnership additional institutional power. As such, partnership has a high degree of efficacy and so it would seem natural to invoke this as an improvement mechanism without necessarily being clear about why – or without being required to define why. It is a given that health and social care partnerships are enacted as they will ultimately bring about better service user outcomes.

Due to the presence of these three different forms of institutional isomorphism and their varied sources, it could be argued that partnership has become a pervasive force within health and social care communities. Not only does the term partnership have political salience, but

it is also seen as a standard response when facing problems of organisational performance and an option that individuals are sensitised to throughout their professional education and subsequent exposure to training and development opportunities. None of the case study sites were able to clearly articulate what it is that they were attempting to achieve in terms of service user outcomes. This may be because partnership is afforded such precedence within health and social care communities that it is not questioned in terms of its efficacy as a response to issues of performance deficit, and is viewed as an inherently positive and rational means to bring about improvement.

All the case studies suggested an underlying faith that inter-agency collaboration had the potential to improve services, to deliver benefits for front-line staff and to bring practical advantages for partner organisations. Yet there was little specificity about what this would actually look like in practice, let alone how this might link to the notion of partnership working. Partnership appears as a “holy grail” which should improve various aspects of services for users, carers, staff and partner organisations alike. As partnership has such efficacy in terms of the institutional setting it is not questioned, but instead appears as the “natural” option to bring about improvement. It is important to note that this is not simply a new or recent observation either. As the structural frame outlined in chapter three illustrated, the need for health and social care agencies to interact could be argued to go back to the establishment of the welfare state and arguably the lure of coordination stretches back even further. The advent of New Labour and the need for partnership is simply the latest in a long line of manifestations of collaboration, building on what has gone before and the efficacy of this term.

Thus, institutional theory tells us that health and social care communities do not simply enter into partnerships as they seem to be the most “natural” or rational or obvious way to overcome a series of specified issues and therefore deliver particular outcomes but because partnership is highly valued in terms of the institutional setting. In this sense partnership might be considered an ‘empty signifier’ (Laclau, 1996); it stands for the universal or ‘the impossible fullness for the community’ that has ‘divested itself of its particularity’ (p. 42). Partnership has come to embody a position where it is generally seen as a good thing; a concept that it is ‘heretical’ to challenge in the words of McLaughlin (2004). Yet, in being a broadly “good” thing to so many different audiences then inevitably this term is formed to divest itself of its specific meaning. If a range of stakeholders are to buy into this concept then its greatest strength will come in being as vague as possible. This is what McLaughlin is referring to when terming partnership as having ‘useful-ambiguity’ in the sense that it promotes and allows multiple interpretations and can mean different things to different people. Or what Glendinning *et al* (2002b) term a ‘humpty-dumpty’ issue (invoking their own metaphors in building this case). What these scholars mean by this term is that if somebody calls something a partnership and others believe it, by definition it becomes one and it will be broadly associated with positive connotations.

Perhaps unsurprisingly when case sites were pushed to articulate service user outcomes they often suggested very ambitious aims for partnerships – ones beyond which a change of organisational structures could feasibly deliver. However, this can become a dangerous tactic in the long term. As chapter one noted, partnerships have started to get somewhat of a “bad press” in some quarters and professionals have often experienced difficulties when working in partnership with other professionals and agencies with rather different procedural, regulatory and financial systems. Moreover, in being rather unclear about what partnerships

are ultimately aiming to achieve there is a danger that they are linked to either overly aspirational outcomes or to issues which are endemic within health and social care communities, but not necessarily directly linked to working in partnership (such as safeguarding, debates over financing of services etc). Under these circumstances it is difficult to be perceived as a success given the difficulties with fulfilling all these expectations.

Whilst this is a helpful analysis to some degree and moves existing perspectives of health and social care partnerships on somewhat from the types of means-ends instrumentalist improvement mechanisms that they tend to be portrayed as within the wider literature, it does not seem to capture the full nuances that were witnessed within the case study sites and which were alluded to in the previous chapter. This account is one which is rather structural in some senses and predominantly views the case study sites as being *done to*, rather than having an active role in shaping their fate. This is where a more performative analysis of culture becomes helpful.

6.3 The power of the performative

As a range of theorists have argued, possibilities for social action are always contextually circumscribed. Local values and cultures therefore have an enormous impact on what possibilities for action there are. This is very much the analysis that is set out in the previous section, in making the case for the adoption of partnership due to the powers of institutional and cultural pressures. However, the work of Judith Butler (e.g. Butler, 1993) has taken this analysis further, building in a more robust account of agency to this picture. According to such an analysis, agency arises out of institutional constructions or what Butler terms

“subject-positions”. Institutional constructions set out what types of behaviours are required locally. Thus, organisational environments serve as the contexts for iterations of required behaviours and as such discipline subjectivities over time. Cultural production and reproduction depends on the iterative citation of organisational values, under the gaze of others. What is important therefore is this notion of citation or iteration being carried out by embodied beings. As such, performativity is ‘neither free-play nor theatrical self-presentation; nor can it be equated with performance. Performativity cannot be understood outside a process of iterability, a regularised and constrained repetition of norms. And this repetition is not performed by a subject; this repetition is what enables a subject and constitutes the temporal condition for a subject’ (Butler, 1993, p.95).

This sort of performative analysis becomes important given the many unstated drivers which were uncovered during the process of research. This did not simply reflect a series of individuals or professionals that were being “done to” by the national or local policy contexts. These individuals were actively involved in shaping how partnership developed and was instantiated within their locales. Butler draws on the work of Derrida in explaining the room for change in processes of citation and iteration. Derrida (1984) speaks of the metaphysics of presence, arguing that action and speech are never fully present. Significance of speech is produced through performing other actions. In other words, actions only ever acquire meaning in relation to other actions and therefore subsequent actions always rely on the meaning attached to previous activities. If there is no “fixedness” or essence to action, this means that performances are both the same and are repeating prior actions, but at the same time different either in terms of their temporal component or in terms of their instantiation. The indeterminacy of citation offers the potential for change within each

iteration. Performance, therefore, is an embodied action which occurs at the end of a chain of prior iterations (Freeman & Peck, 2010).

Viewing partnership from this perspective suggests that local leaders performed partnership through their iterations and citations of this notion. Yet, given the lack of finality of meaning (Laclau & Mouffe, 1985) accorded to partnership, in the instantiation of this notion there is room in which to alter the repetition of this notion. Applying this sort of analysis to the study of health and social care partnerships suggests a very different type of organising to that which is typically inferred. This analysis does not see partnerships as specific mean-ends improvement mechanisms to bring about specific changes in service user outcomes. This does not mean that partnerships might not bring about changes in service user outcomes, but that they may instead play a different sort of role in processes of organising. As was set out in the previous chapter, RISS was going through a series of changes to the boundaries of the integrated services which were badged under the label of partnership. The CP essentially seemed like a form of organisational take over that fulfilled the local political needs of both the main partners. DLDS was undertaking significant processes of modernisation with the locality and again all this was termed partnership.

In the spirit of a notion of cultural performance of partnership, Table 6.1 sets out the “story-lines” of the case studies. As set out in chapter three, story-lines are ways of condensing ‘large amounts of factual information intermixed with the normative assumptions and value orientations that assign meaning to them’ (Fischer, 2003: p. 87). It is not argued that these narratives straightforwardly ‘reveal the past’, but ‘through interpretation they do reveal truths about narrators’ experiences and how they want to be understood’ (Patterson, 2008: p. 31). What this table does is set out the key features of each of the case study sites as observed and

understood by the author. It provides an account of what the problem seemed to be that partnership was responding to, what the manifestation of partnership involved, the impact that this had seemed to have and the difficulties which were also detected in practice. The table also adds to this the unstated drivers of both partnership and rationales for involvement in the evaluation. Drivers for engaging in the evaluation are crucial in the context of the cultural performances of partnership for these iterations and representations of partnership were taking place under the gaze of the researcher. What this also draws attention to is that these are one interpretation of these findings and one that is mediated through the representations of what participants in the research wanted to be seen as to the researcher.

Table 6.1: “Story-lines” of the exploratory case studies

Case Study site	Problem	Solution	Impact	Difficulties	Unstated drivers of partnership and involvement in evaluation
<i>RISS</i>	Need to make services more seamless for children with complex disabilities and their families. Provide a single point of access.	Formal integration of a number of specialist teams.	Children and families happy with services received, very positive about the role of keyworkers. Little idea that services delivered by integrated team, but co-location seen as a positive.	Accessing professionals and services outside of the integrated team. Some employees from health backgrounds felt dislocated. Dissonance between what staff suggested children and families wanted and what they suggested they wanted.	Re-open local debates about which professionals should fall under the remit of the team. Demonstrate that this is an effective team in an attempt at a local “power move”. Shape local concepts of what services should be delivering to local people. Improved working environment and parking for staff.
<i>DLDS</i>	Identified as underperforming LD services.	Formal integration of health and social care teams. Significant changes to local structural, financial, procedural and HR processes.	Improved services according to regulatory and formal performance management bodies. Predominantly perceived to be due to significant period of organisational change, not clear how necessarily directly linked to integration.	A number of the practicalities of these changes were completed and partnership felt to have been “achieved”. Staff did not engage with the research as felt integration was no longer an issue and also pace of modernisation slowed down, although re-invigorated following changes in national context.	Need to engage significant portion of staff in processes of “modernisation”. These may have otherwise been resisted by staff due to the magnitude of change involved. Further address organisational difficulties that come from working across health and social care boundaries.

<i>The CP</i>	Improve services for local children by learning between acute and generalist trusts	Transfer employment of paediatric staff from SHUH to LEH.	Disenfranchised staff at SHUS although concede that access to some better training and use of the LEH logo beneficial. Little perceived impact on services that children received.	LEH staff feeling ostracised from line management and faced with number of practical difficulties on day to day basis. Felt as though LEH had achieved a “takeover” rather than a true partnership. SHUH forced to change practices and cultures to LEH, but no reciprocated learning.	LEH was under possible threat of paediatric services being closed down. SHUH under risk of being forced to change practices so that becomes more generalist in orientation. If SHUH and LEH banded together could lead re-organisation of specialist paediatric services in that city. LEH foundation trust application being prepared.
<i>Newfield</i>	Two small teams providing very specialist services in niche areas.	“Organic” development of services in “bottom-up” fashion. High levels of trust and relational bonds between specific individuals.	Locally perceived as being successful teams.	Staff did not engage at all with the research process. Concern that visibility would lead to desire within the organisation to change horizontal and flat linkages into a more hierarchical arrangement.	Little engagement for fear that this would force the team to formalise relationships and fundamentally change services and the way they are delivered.

Fulop *et al* (2002) conducted research into mergers of NHS provider organisations in England and there are a number of parallels in the findings from this research. Fulop *et al* found that the “official” reasons given for merger were often at odds with the “real” reasons which they determined through interviews with the executive teams. Moreover, these “real” reasons often linked to organisational, structural and political imperatives, whilst the publically articulated drivers were more related to general issues of improvement for service users, the wider public and staff who work within provider trusts. These “mergers” were being publically predicated on the notion that these would make financial savings and improve circumstances for staff, but in practice were actually being driven by other local political and organisational concerns. These researchers found that:

*‘Stated drivers [for merger] ...included a need to make internal savings in management costs and invest savings into services for patients, to safeguard specialist units and guarantee developments in services, to ensure that quality and amount of services provided were maintained... to improve conditions and career prospects for staff and solve recruitment and staff retention problems...Unstated drivers were concerned with specific local issues about one or more of the constituent trusts...These included a need to impose new management regimes on trusts... to negotiate reductions in accumulated deficits ...and to respond to lobbying from stakeholders’ (Fulop *et al.*, 2002: p. 247).*

Fulop *et al* concluded that processes of organisational change are often considered in a simplistic fashion and ignore the ‘dynamic relationship between the organisations and its context and between the organisation and individuals within it’ (p. 119). Yet, in the field of health and social care partnership this warning has not been heeded and studies have often cleaved to rather rationalist and simplistic conceptualisation of organisational change, whereby partnerships are largely viewed in an instrumental fashion.

This thesis represents an attempt to produce a more dynamic and interpretive reading of partnership working within a range of organisational settings. It argues that rather than being seen as a means to bring about changes in service user outcomes, health and social care partnerships are an active form of governance. Whilst publically stating that their ultimate purpose is to improve services and service user outcomes, in practice many of the partnerships explored in the case studies seemed driven by very different factors. This is not to say that partnerships might not lead to better services and improved service user outcomes, but that there are more complex and dynamic processes of organising present in these contexts than this simple instrumental account can do justice to. This thesis develops the work of Fulop *et al* (2002) in providing a robust theoretical account of why and how these processes might take place. It argues that there is not one account of the “real” reasons for organisational change activities, but many.

When pushed to articulate what they were ultimately trying to deliver respondents from the case study sites often became rather aspirational about what partnership would achieve within their locality. For RISS, partnership would *‘facilitate greater service user involvement locally’*, would *‘empower Asian/ethnic minority parents’*, *‘improve starting school experience’* and create more *‘family friendly paperwork’* amongst other things. For DLDS it would *‘modernise day services’*, ensure *‘greater accountability for people from minority community groups’* and *‘provide a single access point between trusts, streamlining services’*. Whilst the CP would *‘reduce unnecessary admissions’*, *‘reduce inequalities in health’* and *‘reduce risk of serious harm to children’*. In not being specific about what these partnerships should achieve beyond very broad statements about making services better for service users and their carers, professionals assumed different perspectives about what “*better*” might actually mean in practice.

In terms of the types of outcomes gleaned through the survey component of POET, it is important to note that in *no* cases were negative perspectives of partnerships articulated. None of those who completed the survey expressed a belief that partnership might be a means through which to gain access to another agency’s resources or to exert power over another partner. Yet, within the wider literature there is a clear sense that partnership is a legitimate means of trying to manipulate the actions of, or to control other partners. Hastings’ (1996) work is a good example of this, based on studies of regeneration partnerships. Hastings’ work builds on that of Mackintosh (1992) which is also generated in the regeneration field. Mackintosh defines synergy when applied to partnerships as ‘the underlying idea...is of two distinct economic sectors, each with identifiable pools of assets and capacities, and with clear and distinct (but not wholly mutually exclusive) objectives’ (1992: p. 213). Hastings builds on this to produce a typology of synergy which is set out in Figure 6.1.

Figure 6.1: Hastings’ typology of synergy

	<i>Process</i>	<i>Outcome/benefit</i>
<i>Resource synergy</i>	<i>Cooperation and coordination over the spending of resources</i>	<i>Added value from the resources spent: increased effectiveness or efficiency</i>
<i>Policy synergy</i>	<i>Joint approach developed through combining the different perspectives of each partner</i>	<i>New perspectives / innovative solutions created. Original differences in culture and objectives between partners maintained</i>

(Hastings, 1996: 260)

In Figure 6.1 there is clear sense that synergy is either formed through having different perspectives coming together but partners retain their distinct identities or that synergy is related to the bringing together of budgets. Across the sites participants talked openly about

the first driver but were usually rather more silent about the second. This observation supports the idea that the efficacy of partnership is in terms of its broadly positive feel and not in processes of resource exchange.

Given the potential that interaction with others holds for partners to change through these processes, Mackintosh constructed a model of transformation that might be used to classify partnerships. Mackintosh labels transformational models of partnerships as being produced where both partners alter each other in some ways. Mackintosh uses the example of public-private partnerships to illustrate this, suggesting that these lead to the public sector becoming more “business-like” and the private sector more socially aware (or, at least, seen as more socially aware through their interactions with the public sector). Hastings develops this notion further, suggesting that other forms of transformation might also exist (Figure 6.2).

Although the CP was originally articulated as being a process of mutual transformation, those at SHUH felt that the outcome has been uni-directional transformation. In the CP some sections of professionals took the opportunity of the evaluation to actively express their concern that the resulting settlement was not a “true partnership” as they did not feel that this was a mutual process of sharing. The “true” partnership they had been promised where all partners would be involved in change processes and new sets of objectives, operational styles are developed would be developed. However, what had been enacted in practice was a process whereby LEH had sought to modify SHUH in their own image. Although staff at SHUH stated that they valued the training that this gave them access to and that they found the badge of LEH helpful due to its national visibility they did not see the need for them to change themselves completely. In fact, in parts SHUH staff had actively resisted taking on an LEH identity as they feared that this would lead them to be ostracised from their own

organisation. Further, as will be discussed below in more detail, at Newfield staff actively resisted becoming involved in the research as they were concerned that this would lead to their “organic” partnership being shaped into something rather different.

Figure 6.2: Hastings’ forms of transformation

	Process	Result
Uni-directional transformation	One of more partners struggle to modify or to change another partner in their own image. Partners do not accept the need to change themselves	One or more partners change their organisational culture or objectives to become more similar to those of another partner. The transforming partner retains its original style or objectives.
Mutual transformation	Reciprocal challenges made to the pre-existing culture and objectives of partners, who seek to learn as well as aspire to teach.	All partners involved in the process change to some extent. New sets of objectives, operational styles are developed. Differences between partners are reduced.

(Hastings 1996: p. 263)

In all of these cases, multiple stakeholders interpreted the meanings of improvement in quite different ways, often aligned to their professional roles and the aims associated with their particular role within their teams. For example, a small proportion of responses gleaned from DLDS suggested that the ultimate aim of the integrated services was to ‘*increase the uptake of cervical screening by women with learning disabilities*’. At the time of the research there was a significant push to increase the screening rates for individuals with learning disabilities in Drumston. However, for this to be considered a key intended outcome of the integrated working arrangements confirms the way in which integration had been enacted in this setting associated with modernisation as it was. This was made all the more likely given that partnerships have tended to emerged as generalised rather than specific means of

improvement. Because partnership is assumed to be a good thing, it is not necessarily questioned in a way that other mechanisms might be. Without being specific about the changes this way of working should bring, then it is more likely to be accepted by the range of stakeholders with their different cultures and values, but this may come at a potential price should these varied expectations later come into conflict with one another.

As chapter five illustrated, when staff at RISS were asked what outcomes the integrated services were aiming to achieve for service users, many named issues which were of concern to them – and not necessarily to families and children. At one level this could be seen as quite a malevolent move where professionals are appropriating setting out service user outcomes for their own gains. There is a vein of the partnership literature that describes the potential of partnerships to be used as “power moves” (Allen, 2003; Barnes *et al.*, 2004). This area of the literature is less positive about the nature of partnerships than most others and talks about the potential for a dark side to partnership. Many partnership initiatives come with the introduction of some form of one-stop-shop or single access point for service users to visit in order to access services. This is presented as a positive initiative and one which should improve speed and ease of access to multiple partners (as was indicated in the previous section). However, Allen (2003) warns against presuming that these mechanisms are always a positive experience for service users. In this case, Allen studied homelessness foyers and observed that increased partnership working led service providers to believe that they were “infallible”. When individuals did not positively respond to interventions then it was the individual, rather than the service, which was viewed as failing. By working together through a single partnership this reduced the choice which service users previously had.

Much government policy suggests that service users wish to be able to access one organisation (rather than several) as it provides ease of access. Yet this occludes another perspective which states that the implication of this is that there is only one source of assistance for service users to approach, and if this fails there is no alternative. In some ways this is a power move and in forming a one-stop-shop this sent clear message to the users of this service about who ultimately holds the power in shaping expectations about accessing services and types of behaviours deemed appropriate. This also has particular connotations in terms of complaints procedures, where there are fewer options within which to pursue a complaint – and service users may be less ready to pursue complaints for fear of being blacklisted by the partnership.

In his article Allen (2003) suggests that some public sector professionals and organisations actively seek to deploy these types of “power moves” and the dissonance in expectations of outcomes could potentially be seen as an extension of this. However, viewed in terms of a cultural performance perspective the view is potentially less negative. This could represent less of a deliberate attempt at a power move over families and children, and more a product of the iteration and citation of embodied inter-subjectivities. The RISS professionals were simply citing what they saw the value of partnership to be or what they understood by this terms given that this had been broadly defined as a “good thing” to them. In its further citation integration then came to mean a range of “good things” as interpreted from the standpoint of these different individuals. This is where the interpretation of the audience becomes important in terms of the successful deployment of this performance. In the case of Allen he viewed this performance as a deliberate attempt of professionals to exert power over the more “problematic” homeless people who sought to access these services. A similar reading of the RISS context might argue that these professionals were aiming to subvert the

purposes of integration for their own ends (i.e. improved working conditions). A more benign reading might be that this is simply what these professionals understood integration to mean given the lack of clarity which had been experienced.

As Pentland and Reuter (1994) argue, organising is, ‘not a stable pattern but, rather, a set of possible patterns, enabled and constrained by a variety of organisational, social, physical and cognitive structures – from which organisational members enact particular performances’ (p. 491). As such the role of rhetoric becomes crucial within these performances. Service user outcomes appear as rhetorical devices throughout many of the constructions of outcomes frameworks set out in the previous chapter. Rather than thinking of rhetoric in a negative sense though, it is taken here as a rather more positive factor. As Gartsen (2006: p. 6) argues:

‘Rhetorical appeals need not and, in fact, must not take the intention to think reasonably for granted. They frequently start from the premises or attitudes shared only by members of the present audience. Often they rely on premises that are not even made explicit; these premises are supplied by the audience itself. In trying to bring an audience from the conventional wisdom to thoughts or intentions they might not otherwise have adopted, rhetoric intends to wield influence over them’.

The performances of those staff members at RISS were enacting their own social, physical and cognitive structures in a manner they would doubtless have witnessed from others within their locale, drawing on rhetorical devices – such as service user outcomes – to make their readings appealing to other audiences.

The CP also could be seen as attempting to produce such a “power move” in setting out its final outcomes framework. After it had been established that the CP did not have a clear outcomes framework to evaluate its activities against, the decision was taken to develop one that could be used to engage current and future partners within partnership activities. In

setting this outcomes framework, the CP sought to situate this within the *Every Child Matters* outcomes. This is an example of the rhetorical value of an outcomes framework. These outcomes are broad and aspirational outcomes (as discussed in chapter one) but this was a tactic deliberately adopted as the abstract nature of these meant that there was something for a whole range of different partners to buy into. This outcome framework was therefore selected as a means to enhance engagement of local partners in the future. The initial work that had been done in terms of the CP was predominantly between LEH and SHUH, but the original intention was that Beddington tPCT and the Fenningham Hospital would be more involved within the next phase of the CP. Setting an outcomes framework which speaks to the underpinnings of the *Every Child Matters* document was seen as a way in which to appeal to the desires and priorities of BtPCT in particular. By demonstrating how the work of the partnership was innately linked to this form of performance management regime it was anticipated that BtPCT might more readily engage in future working arrangements as they would identify these activities as clearly falling within their own remit. LEH was therefore making a concerted effort to appeal to BtPCT and other potential local partners and make the case for their engagement with the LEH-led partnership in preference to other organisational arrangements.

What was being recognised in setting the CP's outcomes framework was that the efficacy of the concept of partnership is such that as a tool of governance it is not one that is simply instrumental. Returning once more to Figure 2.1 and Goodwin *et al's* (2004) analysis of different forms of networks, partnership has symbolic power that draws on aspects of moral suasion to compel individuals and groups into action. Given that inter-agency settings are most frequently comprised of a range of stakeholders with their differing values, cultures, institutions and - importantly - understandings of what constitutes legitimate sources of

power. Under these circumstances, where there is no uniformly accepted source of legitimate power, it is not possible to simply compel individuals into action by drawing on sources of traditional power in a classical management (hierarchy) sense. Moreover, even if it were – for example, in a care trust – then cultural and institutional forces may undermine or disrupt these hierarchical sources of power (indeed this was observed by Dickinson *et al.*, 2007 in a study of a care trust). Given that partnership has such efficacy it may be employed most fruitfully not simply in terms of an instrumental tool of governance, but instead in terms of its symbolic value in compelling individuals and groups into action. The symbolic nature of partnership is such that it appeals to the cultures and values of a range of different stakeholders, in a way that other mechanisms are unable to achieve. Partnership is a shorthand means of appealing to a range of audiences through the value that particular terms imbue without entering into protracted discussions about the specific meanings of terms. These are naturally seen to embody particular meanings to certain audiences and there is a pre-existing understanding of these meanings.

6.4 Partnership and governance

So what does this cultural and performative account of partnership say about the nature of partnership and governance? As the analysis of the health and social care policy context set out in chapter three demonstrated, at the national level the importance of partnership working has been stressed in terms of its impacts for services and consequently for service user outcomes. Yet, an interpretive frame analysis suggested that it has in fact been predominantly used as a way of influencing individuals and groups to engage in the ongoing process of public service modernisation. If this analysis is accurate then we might expect that the partnership concept would have cultural and symbolic resonance within health and

social care communities and this was demonstrated through the review of extant evidence set out in chapter one. The notion of partnership has been privileged at a national level as an important tool of improvement that will make services broadly “better”, but rarely with little more specificity than this.

As demonstrated in chapter three, partnership has been used as a way of: facilitating structural changes (with their attendant impact on the values and cultures of professional groups); as a way of assuaging public fears in relation to high profile issues such as health inequalities, child safeguarding and crime and disorder initiatives; a way of performance managing health and social care communities and the wider locales that they reside in; and, as a way of justifying a political ideology and communicating to the population that an administration is employing effective programmes of improvement. In this sense then, partnership is an active tool of governance which is employed as a political discourse, as a means of steering a community (Kooiman's 1993 definition of governance) and as a mode of social co-ordination or order (Mayntz's 1993 definition of governance). In the language of Foucault (1990), partnership is a part of the ‘ensemble of institutions, calculations and tactics’ (p. 102) that is deployed to arrange services in such a way that certain ends are achieved. Partnership is a means of mobilising often quite diverse stakeholders into action around particular issues which might otherwise be resisted. Partnership makes innovations in organisational change more appealing due to its cultural value.

This proposition goes beyond the traditional types of links which have been made between partnership and governance. As demonstrated in chapter one, the majority of these discussions have considered where partnerships sit in terms of forms of governance (are they networks, are they hierarchies, can they be both?), or why partnerships might be necessary in

the move to New Public Governance given the plural and increasingly pluralist nature of the state. However, within this analysis, partnerships have not been considered as an active tool of governance in a symbolic and rhetorical sense - and one that may be invoked because of its efficacy to steer and co-ordinate particular communities and populations. Governance is, 'the procedures associated with the decision-making, performance and control of organisations, providing structures to give overall direction to the organisation and to satisfy reasonable expectations and accountability to those outside it' (Hodges *et al.*, 1996: p. 7). Thus, governance is much more than structures and processes in an instrumental sense but has symbolic value outside of this, demonstrating the types of values that are represented within that system and which courses of action are considered legitimate within that setting (Contandriopoulos *et al.*, 2004).

Processes of modernisation in Drumston had been strongly linked to the concept of integration. Early on in the process of reform, many changes were made under the banner of integrated working, but it was often unclear how these activities directly related to partnership working. However, changes were made and these were regarded as improvements by inspectors and local stakeholders alike. The lack of engagement with the evaluation was taken to signal a partnership which was no longer functioning effectively; but those that had engaged with the process had been very positive about the experience of partnership working. However, the local head of service expressed the belief that this lack of engagement with the evaluation meant that people were no longer interested in integration and trying to build more effective inter-agency arrangements. As a result of the evaluation his solution was that he needed re-focus the minds of the integrated service around specific modernisation projects where professionals would be required to work together. The service head understood his role as a sensemaker for the wider organisation (Grint, 2005; Pye, 2005)

and sought to utilise this evaluation as one way of re-focusing the energies of the organisation.

In essence, the use of integration in Drumston was more akin to the notion of a “collaborative” improvement methodology. The collaborative approach involves a variety of different stakeholders concentrating improvement activities on a specific service area with the focus of improving performance (see Kilo, 1998). This approach has been widely used in the NHS (for example, the Cancer Services Collaborative, Robert *et al.*, 2003a; the Orthopaedic Services Collaborative, Bate *et al.*, 2002; and the NHS Mental Health Collaborative, Robert *et al.*, 2002; 2003b) where it is generally considered to have been successful.

Integration was used as a means of framing a series of changes towards the goal of improving outcomes for service users. However, one consequence of these changes being linked so clearly to the label of integration was the latter had been implemented, the overall improvements were assumed to have been achieved. When staff did not engage with the first phase of POET to the degree that the Head of Service had expected he took this as an indication that partnership working was no longer “an issue” – and to a number of professionals working on the front line this was true. Other issues had come onto the agenda and working with other professionals and agencies had become an integral part of daily life. The original intention had been to use the evaluation as a way of re-engaging professionals with the agenda of partnership. However, the activities and interest that had nationally started to envelop the issue of learning disability services meant that this local process of re-framing was no longer necessary. National events re-focused LD services on the issue of change and improvement without the issue of integration needing to be engaged.

However, more importantly than this, the evaluation was a cultural performance in the sense that it acted to shape concepts of what local services *should* be delivering; i.e. seamless and joined-up services for local families. RISS engaged in this evaluation in order to produce evidence that would further consolidate their place in local service delivery. This was to be achieved not only through the summative judgement of the evaluation but also the deliberative processes involved within the evaluation. This echoes Sanderson's (2004: p. 376) rhetorical take on rationality in policy processes; 'we need to work within a broader conception of rationality to recognise the validity of the range of forms of intelligence that underpin 'practical wisdom', to acknowledge the essential role of fallible processes of craft judgement in assembling what is to be accepted as 'evidence', and to incorporate deliberation, debate and argumentation in relation to the ends of policy and the ethical and moral implications of alternative courses of action'. The decision to engage with this research went far beyond a simplistic decision relating to instrumental rationality, but instead illustrates an innate understanding of the means through which stakeholders might be influenced locally through processes such as evaluation.

What is most interesting about this account of governance and partnership is the only site which arguably was the kind of "true partnership" that many stakeholders referred to was Newfield. In this area there were two small teams that had grown up in a rather organic fashion and could be characterised by their more informal relationships. However, this was the only site which went to pains NOT to describe itself in terms of a partnership. This account also vividly illustrates the agency of local actors to shape and to resist policy. Stakeholders at ND were essentially suggesting that they did not wish to become involved in the research as this would draw attention to their activities and the standard organisational

response under these circumstances was to attempt to turn networks into hierarchies. This is interesting in that it represents an attempt to resist hierarchy. In the words of Hajer, the story-lines set out so far in this chapter have tended to suggest limited agency on the part of those operating on the front lines of the partnerships. Although some of the respondents at RISS appropriated the opportunity to conflate service user outcomes with improvements to their immediate environment, there were few other examples of agentic action in the narratives set out. This is important to note because this argument is not an attempt to suggest that partnerships are simply a mode of coercing groups of stakeholders into conforming in a Foucauldian sense (e.g. Foucault, 1977). Collinson notes: ‘The persistence of resistant selves underlines that leaders cannot always control followers/ perceptions, identities and practices’. According to Collinson’s argument, resistance in the workplace is under-researched but is crucial as it is not only ‘a primary means through which employees may express discontent, but it is also a way for followers to construct alternative, more positive identities to those provide or prescribed by the organisation’ (p. 184).

In the case of the teams at Newfield, the value of the enclaved teams with their associated bonds of trust was privileged over attempts to draw attention to the activities of these teams and to celebrate their successes. As suggested in chapter three, a number of commentators have had a tendency to associate “true” partnership with the notion of a relational network where actors have complementary interests and develop interdependent relationships based on trust, loyalty and reciprocity to enable and maintain collaborative activity. Arguably, Newfield was the site that had the “truest” partnership in this sense and yet they were resisting the evaluation as they feared that by drawing attention to this arrangement it would lead in the long term to something more akin to a hierarchical relationship: one that is more familiar to classical management theory and the public sector.

6.5 The importance of being efficacious

Against a policy background that seems to continually reiterate both the importance of partnerships in improving service user outcomes and an administration which explicitly embraced the importance of evidence-based policy and practice, this research initially set out to test whether health and social care partnerships had an impact on service user outcomes. Operating under a “rationalist” model of policy analysis, having little data which demonstrates a link between partnerships and improved service user outcomes could potentially lead to the conclusion that health and social care partnerships have failed. However, reaching such a conclusion would mean operating under a rather simplistic notion of rationality, where this is considered as abstract and technological, rather than a situated and culturally mediated notion.

What this chapter has sought to illustrate is that partnership is not simply and straightforwardly a tool of improvement that has been enacted in these four local areas to bring about specific improvement to service user outcomes. This is not to say that these local health and social care communities do not provide high quality services to their constituents, but that the primary means through which they have achieved these is not first and foremost the partnership arrangements. The power of partnership is in its cultural value which might be harnessed as a way of influencing individuals and groups into taking part in activities which they might otherwise resist. Being defined as having a broad (and vague) purposes relating to making services and outcomes “better” for service users helps to persuade a wide range of stakeholders to engage.

Against this background, at a local level, the enactment of health and social care partnerships and the process of these sites being involved in evaluations of their activities demonstrates a range of ways in which cultural performances are enacted. All of the case study sites employed political discourses of partnership and evaluation as a means to bring about change in their local areas and engage other stakeholders in these processes of change. The ‘story-lines’ of the case study sites have been set out in this chapter to illustrate how they, ‘suggest unity in the bewildering variety of separate discursive components’ (Hajer, 1995: p. 56).

Within these conceptualisations of change, the notion of rationality was not predominantly informed by technical notions of effectiveness and efficiency, but instead efficacy appears at the fore. These case studies do not provide evidence of the ineffectiveness of partnerships in their inability to demonstrate specific outcomes. Rather, they show the ways in which local leaders have engaged these terms in order to deliver their desired organisational outcomes and to influence others towards their preferred courses of action. In doing so, individuals within the case study sites demonstrated an intricate understanding of their institutional context. As Miller (1990) suggests in a study of decision-making in healthcare, rhetorical rationality may only be understood from a situated position:

‘Scientific rationality emphasizes substance when it assumes that objectively correct decisions are achievable. It emphasizes procedure when...it assumes that they are not; what procedure can guarantee, rather than correct results, is optimal results from any given starting point. Rhetorical rationality, on the other hand, must emphasise the interdependence of substance and process. As a process, deliberation both requires and creates substance, this is, systems of meaning. The deliberative processes of reason-giving, inducement and change can yield at least temporary agreements, the substance of which depends upon the substance of previous beliefs and the effects of rhetorical are upon them. History, convention, insight, emotion, and value all become rational, that is, possible ‘good reasons’ (Miller, 1990: p. 178).

These kinds of rhetorical rationalist analyses were observed within each of the case study sites, where partnership was being specifically engaged as an active tool of governance and a means of influencing local actors into action. This is an original contribution to knowledge; one which goes beyond typical extant studies of partnerships and governance which tend to conceive of partnership as a heuristic for analysing relations between agents. This analysis instead conceives of partnership as political discourse and as a device with immense cultural value in its own right that might be engaged to fundamentally alter the patterns of interactions between bodies. The value of partnership is therefore in terms of its cultural efficacy and the ability to rhetorically engage this concept in practice in order to control activities within organisations and yet simultaneously appear as the type of services with which local organisations should engage.

Chapter Seven: Conclusions

7.1 Introduction

This thesis has set out to provide a review of the policy of partnership as implemented in the fields of health and social care. Studies of partnership in these areas have long been dominated by rationalist assumptions and often lacking theoretical exposition. This research programme originally set out very much in this type of rationalist vein attempting to establish a link between partnership working and service user outcomes. This was to be achieved through the design and utilisation of a toolkit (POET) that would facilitate this process. However, difficulties were encountered in trying to establish impact on service user outcomes as each consecutive site found it problematic to articulate quite what they are trying to achieve in terms of service user outcomes. It was at this point that the assumption that partnerships are ultimately orientated towards a desire to improve service user outcomes started to be questioned. If these partnerships could not identify the types of outcomes that they were seeking to improve were they actually driven around this aim? If partnership was the answer, then what was the question?

The conceptual underpinnings of the research were at this point re-oriented to an interpretive analysis of partnership; one which considers policy not as instrumental means of bringing about specific changes but as symbolic means through which actors may legitimate particular forms of action. It was argued that the efficacy of concept of partnership and its association with positive connotations of improvement appealed to a wide range of different audiences and has been used as a way of engaging individuals and groups in processes of change which they might otherwise have resisted. Moreover, most of the resulting activities that have gone on under the guise of trying to produce better outcomes for service users have actually been

in a number of cases means of making a range of organisational changes that are quite unrelated to the interests of service users. Partnership, therefore, is not a discrete policy intended to bring about changes in service user outcome but instead is an active tool of governance that controls the actions of those who operate within the partnership but also satisfy the expectations of those outside it.

7.2 Overview of the narrative of the research programme

Health and social care partnerships are most often publically predicated on the basis that they are a means to bring about improvements in service user outcomes. Yet a review of the theoretical literature underpinning the notion of inter-agency collaboration illustrates that there are a range of reasons why organisations might enter into partnerships, and that access to resources seems to be a prevalent driver given the influence of the discipline of economics. An interpretive review of the national partnership policy context further suggested that although service user outcomes were present rhetorically within each of the frames identified, they were by no means central to any. These frames variously constructed the “problem” that partnership was set up to address and this in turn influences how and where the “solution” of collaborative efforts are focused.

The review of evidence relating to the outcomes of health and social care partnership working in chapter one further illustrated that the greatest impact that this way of working has demonstrated is in terms of its efficacy. Although there is some evidence pertaining to efficiency and effectiveness of partnership, this is patchy at best and hardly compelling given that collaboration has been such a focus of health and social care policy initiatives over the

past decade. This could be considered problematic given that partnership working is most often predicated on the basis that this is ultimately aiming to improve service user outcomes. Some commentators have suggested that this lack of evidence is due to the difficulties encountered in evaluating partnerships. The three major difficulties which are normally cited in this respect are: the use of partnership as a rather generalised and catch-all term; attributing changes to activities of partnerships; and, the complexity of the environments that partnerships operate in. However, it is argued in this thesis that the most significant difficulty is that this makes two fundamental assumptions about the nature of partnership working that are not necessarily borne out in practice. The first is that partnerships are fundamentally concerned with improving service user outcomes. The second is that there tends to be an implicitly rationalist and instrumentalist model of policy analysis implied in these types of studies.

Much of the partnership working literature is not particularly theoretically robust or is lacking in conceptual exploitation. There is also a tendency in this literature to be overly empiricist, descriptive and hence often prescriptive about what effective partnership working is and what the crucial components should be; albeit without ever defining what is meant by effective partnerships. This thesis adopts a different style of analysis; one that is both interpretive and performative. This framework of analysis suggests that partnership working has never been driven purely by a normative desire to improve service user outcomes. By examining the range of theoretical and conceptual constructs which seek to explain why inter-organisational relationships exist it would appear that none of these models have the improvement of service user outcomes as a core aim. What these models are predominantly driven by is a desire to access or control the resources or power of another agent. Analysing the policy context from an interpretive perspective reveals a series of different problems that partnership is suggested

to be responding to. The identification of multiple problems is important as these have implications for the manner in which the solution is constructed and ultimately why partnership is thought to be necessary and what it is intended to achieve.

An analysis of the evidence of what partnerships have demonstrated to achieve in practice illustrates that measures of effectiveness and efficiency have been much more frequently used in making judgements about their success than measures of efficacy. Yet, arguably there is more evidence about the impact of partnership working that relates to efficacy than the other two measures. Efficacy relates to the extent to which an organisation is perceived to be achieving outcomes that are valued by its main stakeholders and accords with concepts of “rightness”. Partnership is more powerful as a symbolic and rhetorical policy tool, than purely as an instrumental approach to improvement.

Given this observation, partnership might be used to engage a series of different stakeholders with a range of contradictory and competing values and cultures towards improvement activities that might otherwise be resisted, all under the rhetoric of improved service user outcomes. However, there is a danger in this tactic. The rhetoric of service user outcomes has been applied to a range of diverse expectations such as; safeguarding individuals from abuse and the public from individuals with particular mental health conditions, debates over financing of services and easing tensions between professions that have fundamentally different concepts of how welfare services should be delivered. Yet it is not clear if, or how, these issues relate to partnership working and most of these issues have been endemic in health and social care communities for some time. To expect partnership to tackle these issues is problematic and will likely lead to this notion losing its symbolic value in the long-term as it is judged not to have achieved.

The analysis proposed in this thesis suggests that in partnership working has never been solely concerned with the improvement of outcomes. It is not a means-ends mode of improvement. Instead it is an active tool of governance which has been used to engage individuals and groups in particular activities and whilst appearing to stakeholders as appropriate and legitimate means of service delivery. This interpretive and performative conceptualisation of partnership working was further developed and refined through the discussions of the case study sites and the research findings that were generated from the POET process. The case studies demonstrated the ways in which partnership has been engaged as a rhetorical device for engaging a variety of constituent groups in processes of change, and often towards particular changes that otherwise might be resisted. Most of the case study sites were undergoing significant processes of change and these were framed using the notion of partnership and improved service user outcomes in order to mobilise varied stakeholders into action.

The only site where this did not take place was the one where it could be suggested that “true” partnership existed in the sense that many of the characteristics of these working relationships accorded with network-like notions of governance. In this case the professionals resisted being involved in the research for fear that being recognised as effective partnership teams would mean that they would inevitably be turned into some form of hierarchy as does tend to traditionally happen in order that this organisational form might more closely align with more familiar notions of accountability.

7.3 Original contributions to knowledge

This thesis makes a number of contributions to the existing knowledge base. These contributions are both empirical and conceptual in nature. The first is the creation of POET. This developmental evaluative tool is now beginning to be used in a wide variety of different health and social care partnerships throughout England. POET is currently being refined based on the experience of the research programme and a new version will be made freely available online to health and social care communities around the country to use within their local areas. The idea is that sites will use this resource free of charge but will report details about their findings back to the host (Health Services Management Centre) so that we might be able to make conclusions about partnership working based on a much larger data set than is currently available.

The other prominent contribution to knowledge that this thesis makes is conceptual. The interpretive and performative analysis of partnership working is not one which has been previously exploited. This seeks to explain partnership not in normative, rationalist and instrumental terms as has typically been done; but instead considers partnership as an active tool of governance that may be used to engage actors in processes of organisational change that they might otherwise resist. Given the efficacy of the term partnership it has been utilised to label a whole series of reforms which are publically predicated on the basis that they are intended to improve service user outcomes, yet in practice rarely relate to these but instead to a whole range of other local political and organisational drivers. This provides a fundamentally different means through which to conceptualise partnership working than currently exists within the wider literature.

7.4 Possibilities for future research

So where does this thesis leave us in terms of future research? This thesis has posed a challenge to the extant health and social care partnership literature by suggesting that it needs to embrace theoretical traditions that extend beyond rationalist, empiricist and instrumental models of policy analysis. Furthermore, this thesis has set out and developed a theory of partnership working which is instead interpretive and performative. It has been applied to a limited number of case study sites, but would benefit through further refinement within other settings. From the applications of POET in practice it appears that the major source of refinement needed is in the process of articulating outcomes. Individuals found it difficult to do this for the reasons already well rehearsed within this thesis but this could be made easier through a more structured process. I am currently working with Q methodology (Brown, 1980; 1996) as a potentially more effective means of articulating the outcomes that individuals believe their partnership is trying to achieve. This process differs from the existing approach as it offers participants a series of statements about outcomes to choose from – rather than generating their own. As a means of investigating wider experiences of partnership there is also potential to utilise POET within different settings, for example criminal justice partnerships, leisure, safeguarding and so on to examine whether similar experiences are shared in these contexts.

However, there are other approaches to researching partnerships that go beyond simply the use of POET. As chapter six suggested, one of the limitations of this approach is that the performances of individuals have to some extent be taken at face value. Although this process involved some observation of meetings there was not an in-depth immersion into these partnerships which a more ethnographic approach would offer. Further in-depth work employing these types of methods might offer a more dynamic perspective of these

organisational contexts, as might the inclusion of more than one researcher. From a performative standpoint the interpretation of the nature of the deployments of performances lies in some part with the audience perspective. As this research was conducted for a PhD thesis and by the author alone then further diversity in terms of a research team might have added a different dimension to data collected.

In terms of the concept of partnership it is clear that if it is to be engaged as a tool of improvement then it will only be successful if it is able to identify the types of outcomes it is trying to achieve. Without this clarity then this will continue to be seen as somewhat of a vague term and mobilise individuals into action, but not necessarily for the types of outcomes that are anticipated. Specifying the types of outcomes that partnerships are to achieve may also be important for another reason. As articulated in chapter one, the term partnership may presently be reaching the limits of its efficacy. A number of different commentators have been negative about this term and the lack of evidence supporting partnerships and their link to service user outcome. Further, there have been a number of breakdowns in relationships and professionals expressing concerns that partnerships seem to add more, rather than less complexity, to their roles on an everyday basis. If a generalised notion of partnership continues to be predicated on the idea that it will improve service user outcomes but with limited evidence to support this proposition, there is potential for professionals to lose faith in this way of working and resist its application in practice. This may prove problematic in the future for those professionals who do inevitably work on the borders of agencies.

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Volume Two

Appendix One: Academic papers derived from thesis

Appendix Two: Screenshots from POET

Appendix One: Academic papers derived from thesis

Guest editorial: Partnership working in health and social care

Jon Glasby BA MA/DipSW PhD PG Cert (HE), Helen Dickinson BA MA and Edward Peck BA DipPM DipHSM MSc PhD
Health Services Management Centre, University of Birmingham, Birmingham, UK

Internationally, many developed countries are struggling with issues of fragmentation and lack of continuity in services for people with complex needs. Seemingly irrespective of the details of individual systems, there are major difficulties involved in bringing together health and social services to provide a more joined-up and holistic response to people with cross-cutting and multiple needs, whether these be frail older people, people with mental health problems, people with learning difficulties, or whoever. In different contexts, key barriers seem to include structural divisions, separate legal and financial frameworks, distinct organisational and professional cultures, and differences in terms of governance and accountability.

Despite this, there is growing recognition that multi-agency responses are necessary to deal with the complexity of the social problems which we face, and to respond to changing demographics. In the UK, for example, partnership working between health and social care is a central feature of current policy, and the focus of a significant range of activities at a local level. Although there has long been a recognition of the need for interagency collaboration to provide seamless services for users and carers (e.g. see Mears & Smith 1998, Glasby & Littlechild 2004), this has acquired increasing impetus following the commitment of the New Labour government to achieving 'joined-up solutions' to 'joined-up problems'.

Although there is a substantial and growing literature on partnership working (e.g. see Hudson 2000, Payne 2000, Rummery & Glendinning 2000, Balloch & Taylor 2001, Glendinning *et al.* 2002, Sullivan & Skelcher 2002), there are a number of limitations to our existing knowledge (Glasby *et al.* 2003):

- There is a tendency to focus on the perspectives of policy-makers and managers without adequately exploring the views and experiences of service users, carers and front-line staff.
- Much of the current literature is descriptive and sometimes very 'faith-based', emphasising the perceived virtues of partnership working without necessarily citing any evidence for the claims made.
- Little of the literature attempts to place narrative accounts in the context of the existing theory around organisational behaviour or to analyse the dynamics of the relationships which develop over time.

- There is a tendency to view health and social care in isolation without locating them in wider partnerships (such as local strategic partnerships) or placing them within the context of the current emphasis on 'joined-up government'.
- While previous work has focused on the governance of partnerships, we know less about the management of partnerships.

Above all, however, a recent literature review has suggested that the evidence to date focuses on the process of partnership working (How well are services working together?), not on the outcomes of partnerships (Do they make a difference to services, or to outcomes for users and carers?) (Dowling *et al.* 2004).

Against this background, the University of Birmingham School of Public Policy held an international symposium, and this special issue includes papers first presented there. The papers are an attempt to explore the management of partnerships, and the perceived relationship (if any) between partnerships, services and outcomes (see Figure 1). For example, do partnerships really lead to better services and better outcomes (as suggested in much recent policy)? How and under what circumstances does this happen? How should partnerships be managed to achieve maximum benefit? How robust is the evidence base?

In the opening paper, Dickinson reviews previous approaches to evaluating health and social care partnerships, proposing an alternative theoretical framework that may enable partnerships to understand more about the extent to which their work contributes to better outcomes for people who use services. Next, two international papers draw lessons from North America and from the European Union, summarising the results

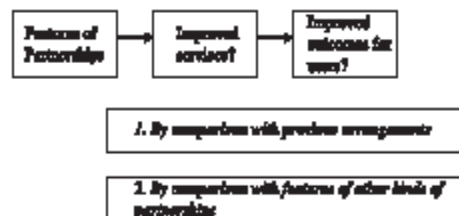


Figure 1 Effective partnership working (in theory).

from studies of integrated care projects for older people (Kodner) and of the management of integrated care (Nies). Two UK case studies then follow, with Henwood reviewing recent UK policy with regard to delayed hospital discharges, and Freeman & Peck examining the outcomes of integrated mental health teams. In these papers, Henwood's in-depth knowledge and personal experience of the policy process gives an important lesson in how *not* to implement policy, and Freeman & Peck reflect on the enactment of partnership at local level.

After this, two papers explore the evidence base with regard to interprofessional education. While Taylor & Le Riche report findings from their systematic knowledge review and practice survey of the learning, teaching and assessment of partnership work in pre-qualifying social work education, Barnes *et al.* explore the outcomes of a post-qualifying interprofessional mental health course designed to facilitate partnership working with service users. Finally, Branfield & Beresford provide an important reminder of the need to remain focused on delivering user-defined outcomes and concepts of quality, building on the unique expertise and contributions of people with experience of using services.

Hardly surprisingly, many of these papers pose more questions than answers, but we hope that this special edition can help to shift the focus away from seeing partnerships as an end in themselves, towards a more critical stance which sees partnership working as

a means to an end – perhaps sometimes able to lead to better services and better outcomes for service users, but not always automatically the best way forward.

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The evaluation of health and social care partnerships: an analysis of approaches and synthesis for the future

Helen Dickinson MA BA

Health Services Management Centre, University of Birmingham, Birmingham, UK

Correspondence

Helen Dickinson
Health Services Management Centre
University of Birmingham
Park House
40 Edgbaston Park Road
Birmingham
UK
E-mail: hed496@bham.ac.uk

Abstract

At a time when health and social care partnerships are continuing to occupy a central role within the UK government's policy strategy, researchers are increasingly being required to evaluate such organisational entities. This paper looks at a wide range of approaches which have been utilised to evaluate health and social care partnerships, and suggests that theory-led strategies are better able to address the complexities associated with such forms of evaluation. In particular, the author suggests that a combination of theories of change and realistic evaluation seems to be the most fruitful in tackling the evaluation difficulties associated with partnerships. Despite both being theory-led evaluation strategies, they fulfil quite different and complementary roles. However, both these approaches have been found to have some limitations in practice. Therefore, this paper suggests that interpreting these approaches through a framework of critical realism may overcome a number of these difficulties.

Keywords: critical realism, evaluation, partnerships, theory-led

Introduction

In recent years, concepts of partnership and collaborative working have risen in prominence within the UK and international policy fields (Clarke & Glendinning 2002, Sullivan & Skelcher 2002, Ham 2004). Essential to New Labour's so-called 'Third Way' of modernising health and social services is the concept that agencies working together across the divide will result in better outcomes for service users. The recent joint health and social care White Paper (Secretary of State for Health 2006), and the reconfiguration of primary care trusts (PCTs) to promote co-terminosity between health and local government bodies would indicate that the trend of partnership working in these domains is showing little sign of abating.

Because partnership working continues to be central to the public services agenda, high-profile evaluations are ever more likely to involve partnerships. Theory-led evaluation has recently become an increasingly popular approach to partnership evaluations. Approaches like Theories of Change (ToC) and Realistic Evaluation (RE)

have been embraced in an attempt to open up the 'black box' of evaluation, and so be able to attribute outcomes to specific mechanisms and processes.

The present paper analyses a number of the key approaches, both method- and theory-led, which have been used to evaluate health and social care partnerships and looks at their relative strengths and weaknesses in practice. The paper addresses why theory-led techniques have proved to be more appropriate to such types of evaluations, but also some of the issues which these approaches have encountered in practice. The paper concludes by suggesting that a number of these difficulties may be overcome by combining ToC and RE, and interpreting them through a framework of Critical Realism (CR). Combining ToC and RE enables both microlevel and grander programme theories to be addressed, and both have already been used as an approach in some partnership evaluations, but by themselves, have encountered some practical difficulties. However, interpreting these approaches through a framework of CR allows us not only to bridge a number of the tensions between quantitative and qualitative

research, but also those between ontological realism and epistemological relativism, thus accommodating views of multiple stakeholders in a search for what works for whom and under what circumstances.

Partnerships and evaluation

One of the fundamental difficulties encountered with partnerships and their associated evaluation lies in a definitional problem. A variety of terminologies such as partnership working, collaborative working, integration and joint-working have been used to refer to this phenomenon, often interchangeably. Drawing on work from Peck (2002), Glasby (2005, p. 30) suggested that health and social care partnerships may be illustrated on a continuum of depth and breadth (Figure 1). Adult services are represented by the open circle to the left of the diagram, and children's services by the open circle to the right. Glasby (2005) goes on to suggest that both services are attempting to move towards the filled circle, but in practice, there is great variation between organisations. Thus, partnerships are not a normative concept, but vary in the depth of involvement of agencies within the relationship and also the numbers of stakeholding partners incorporated with their associated agendas.

Furthermore, partnerships have very different purposes, and accordingly, there are a number of different models of partnership (e.g. see Mackintosh 1992, Hastings 1996, Stoker 1998). Moreover, within these models, it is likely that different stakeholders will have different goals and aspirations. The differences in professional values of medical, other health and social care staff have been well documented (Barrett *et al.* 2005), but it

is also likely that the values of service users and the general tax-paying public will also differ somewhat from those of the professionals.

Research into health and social care partnerships has been found to be more heavily centred on process issues, whilst much less attention has been given to outcomes in both a user and organisational sense (Dowling *et al.* 2004). Nevertheless, many government health and social care publications predicate partnership working on the grounds that services should be organised around the needs of individuals, rather than on a functional basis (e.g. see Department of Health 1998, p. 3). However, the same documents have also tended to concentrate more on the means for delivering health and social care than the actual outcomes (Henwood 2006). Given this governmental focus on means and structural issues, it is perhaps not surprising that research has also tended to focus on these aspects. Consequently, the notion that partnership working should improve services for users remains largely unproven.

Although a number of 'partnership assessment tools' (e.g. see Local Government National Training Organisation 2001, Hardy *et al.* 2003, Health Development Agency 2003) have been developed and used fairly widely, these are predominantly concerned with process issues. These tools aim to understand the many complex organisational issues and relationships between partners in order to aid development and move forward. They are generally cheap, quick and cost-effective, whilst designed to be generic and so applicable in a wide range of contexts. However, these tools do not provide a comprehensive framework, and do not make explicit distinctions between inputs, processes and outcomes of successful collaboration (Asthana *et al.* 2002). It cannot be presumed that, because a partnership is operating effectively, that resulting services are what users want or expect. Thus, in order to be appropriate, evaluations must take into consideration the characteristics of the partnership that they are addressing and the goals which they are pursuing, and balance a wide range of values.

Method-led evaluation approaches

Table 1 outlines the main method-led approaches which have been employed within partnership evaluations. There is a fundamental tension between quantitative and qualitative approaches that has been fairly well rehearsed throughout much of the wider methodological literature. The quantitative approaches used within partnership evaluations have tended to produce broadly generalisable results over a fairly large population, but are unable to highlight individual differences

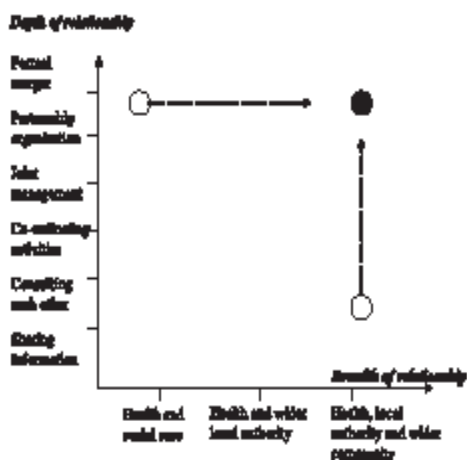


Figure 1 Depth versus breadth of partnership relationships.

Table 1 Method-led evaluation approaches to partnership evaluation.

Approach	Brief description	Strengths	Limitations in practice	Example studies
RCT	Seeks to control as many variants as possible in order to isolate relationships between the variables which are the subject of the study. Only by exerting such experimental control can the observer be confident that any relationships observed are meaningful and not caused by extraneous forces. RCTs aim to make the comparison group as similar as possible to the group under test so that it clarifies the intervention-specific benefits, but by being randomly chosen, eliminates bias	<ul style="list-style-type: none"> - The 'gold standard' within healthcare evaluation, against which other forms are assessed for methodological 'purity' in their attempts to eradicate bias (Davies <i>et al.</i> 2000) - Can cover large service user groups - Ability to generalise results 	<ul style="list-style-type: none"> - Failure to unlock the 'black box' and assess the processes within the partnership leading to attribution issues - Difficulties associated with the randomisation process (particularly ethical considerations in relation to healthcare interventions) - Problems in identifying unintended consequences 	Comparison of outcomes of different models of day care for older people (day hospital and day care) (Burch & Borland 2001, Burch <i>et al.</i> 1999)
Non-randomised comparative design	Seeks to control a number of variants in order to isolate relationships between the variables which are the subject of the study. Only by exerting such experimental control can the observer be confident that any relationships observed are meaningful and not caused by extraneous forces. Compares outcomes for two sites selected to be as similar as possible in characteristics	<ul style="list-style-type: none"> - Seeks to eradicate as much bias as possible through experimental approaches - Can cover large service user groups - Ability to generalise results 	<ul style="list-style-type: none"> - Failure to unlock the 'black box' and assess the processes within the partnership leading to attribution issues - Difficulties associated with identifying homogenous groups - Problems in identifying unintended consequences 	Comparison of clinical outcomes of patients served by integrated health and social care teams and more 'traditional' GP primary health arrangements (Brown <i>et al.</i> 2003, Davey <i>et al.</i> 2005, Levin <i>et al.</i> 2002)
Qualitative methods	Tend to take more grounded approaches to research; for example, through interviews and case studies of individuals and families. Such approaches tend to reject the 'naïve realism' often associated with quantitative methods, i.e. a belief that there is a single, unequivocal social reality or truth which is entirely independent of the researcher and of the research process; instead, there are multiple perspectives of the world which are created and constructed in the research process (Lincoln & Guba 1985)	<ul style="list-style-type: none"> - Accommodates multiple user perspectives - In-depth account of process and context issues 	<ul style="list-style-type: none"> - Quite labour intensive, studies tend to be unable to incorporate large numbers of users with same resources as quantitative approaches - Difficulties in generalising results to other groups - Attribution difficulties; individuals unable to identify actions and policies and their direct effects 	Evaluation of multi-agency organisations working for children with disabilities and complex healthcare needs to assess their impact on professionals, families and the users (Townsley <i>et al.</i> 2004; Abbott <i>et al.</i> 2005)
Multi-method approach	Combines both quantitative and qualitative approaches to gain the advantages of both types of approaches. However, such an approach often involves the researcher hopping from one epistemological base to another (Chen 1990, Pawson & Tilley 1997)	<ul style="list-style-type: none"> - 'A simultaneous multilevel multimethod (quantitative and qualitative) approach to research on partnerships is optimal, thus drawing on differing frameworks and seeking to embrace the perspective of all stakeholders and the complexity of the phenomena under study' (E Ansari & Weiss 2006, p. 178) 	<ul style="list-style-type: none"> - Such an approach does not necessarily overcome issues of attribution - Epistemological inconsistencies - Difficulties of consolidating data from different frameworks - Which stakeholder perspectives should be accepted? 	Evaluation of the first combined mental health and social care provider in the UK, Somerset Partnership NHS and Social Care Trust (Peck <i>et al.</i> 2002)

(RCT) randomised controlled trial; (GP) general practitioner; and (NHS) National Health Service

over any large group. Qualitative approaches seem far more able to accommodate such differences, but are much more resource-consuming, and are likely to incorporate much smaller sample sizes. Moreover, neither approach seems sufficiently able to deal with issues of attribution, whilst this is a central consideration of theory-led approaches.

Method-led and theory-led evaluation

Debates in evaluation have traditionally been methodologically based between advocates of quantitative and qualitative approaches (Lincoln & Guba 1985, Campbell & Russo 2001, Stame 2004). Method-led approaches tend to suggest that many of the problems in evaluation result from methodological shortcomings, thus refinement of research methods alone will lead to the solution of difficulties (Chen 1990). In contrast, theory-led evaluation grew out of programme theory and argues that method-led approaches tend to maximise one type of validity at the expense of others (Davies 2000). Rather than inferring causation from the input and outputs of a project, theory-led evaluation aims to map out the entire process (Pawson & Tilley 1997). This then allows the researcher to say with confidence which parts of the programme worked and why, whether they would be applicable to different situations, and if there are any positive or negative effects which would otherwise not be anticipated (Birkmayer & Weiss 2000).

Gambone (1998) suggested that data collected without 'theory' has the status of 'information' and is limited to describing phenomena, while data collection guided by theory produces what can be called 'knowledge'. However, theory-led evaluation is not without its critics. Scriven (1998) argued that theory and evaluation are separate entities, and it is quite possible to understand the external theory of a programme (e.g. what kind of effects certain kinds of intervention can have) without knowing anything about how the programme produces the outputs (e.g. the internal theory of the programme). However, as commentators like Weiss (1999) and Patton (1997) have pointed out, while this may be true for some small projects, the sorts of projects which today's evaluators are asked to work on tend to address 'wicked issues' which are multifaceted and which partnerships are increasingly set up to tackle. In these cases, if we treat the programme like an on-off switch, we have to distinguish its effects from all the other factors which could lead to an on-off result. Thus, because of the complexity of partnerships and concerns over issues of attribution, theory-led evaluation has become more and more frequently embraced within partnership evaluations.

Theory-led evaluation approaches

Table 2 outlines the two main theory-led approaches which have been employed in the evaluation of health and social care partnerships. Whilst these models offer much to evaluation in a theoretical sense, as outlined above, a number of difficulties have been encountered in practice, as Table 2 indicates. Despite the expectation that these approaches should be able to deal with issues of complexity (e.g. multiple goals and stakeholder perspectives) more successfully than method-led approaches, both have been accused of being overly linear in conceptualisation (Office of the Deputy Prime Minister 2005). Complexity Theory (CT) suggests that the behaviour of partnerships will result from a dynamic interaction between the component parts over time and emerge as the 'holistic sum' of these interactions (Sanderson 2000). Thus, the linear formations by which ToC and RE are typified are not representations of 'reality', which is characterised by many more linkages and epitomised by emergent properties.

In addition, there have been concerns expressed about the multiplicity of meanings and values within such a complex system, replete with multiple stakeholders. Dahler-Larsen (2001) illustrated the importance of seeing systems as open and constructed by social and institutional forces of which individuals will often be unaware. Thus, it has been suggested that ToC and RE are unable to incorporate some key issues which have particular salience within partnership evaluations. In particular, Barnes *et al.* (2003) suggested that ToC and RE would benefit from the incorporation of concepts from Social Constructivism, CT and Institutional Theory.

Consolidation of Theories of Change and Realistic Evaluation

Some studies have used both theory-led approaches outlined above, typically with ToC embedded within RE (e.g. see Barnes *et al.* 1999, Secker *et al.* 2005). Despite both being theory-led, the approaches actually fulfil quite different roles, and complement each other in a number of ways. First, ToC and RE contain significantly differing functions for the evaluator: ToC is prospective with the evaluator involved in an iterative process with the evaluation, whilst RE is retrospective and positions the evaluator in a much more 'traditional role' of outsider. Moreover, one of the primary aims of ToC is involving a wide variety of stakeholders within the evaluation process, which is usually less associated with RE. By locating ToC within a RE framework, one may gather multiple stakeholder theories, and from these, retrospectively identify the key context, mechanism and outcome (CMO) configurations. Indeed,

Table 2 Theory-led evaluation approaches to partnership evaluation.

Approach	Brief description	Strengths	Limitations in practice	Example studies
ToC	A 'systematic and cumulative study of the links between activities, outcomes and contexts of the Initiative' (Connell & Kubisch 1998, p. 18). This approach involves stakeholders surfacing the theories underpinning how and why a programme will work in as fine detail as possible, and identifying all the assumptions and sub-assumptions built in to this process. ToC is concerned with theorising prospectively, rather than retrospectively (Connell & Kubisch 1998), with the majority of surfacing exercises taking place during the planning stage of an initiative where there is an opportunity to explore a number of competing theories between stakeholders	<ul style="list-style-type: none"> – By specifying what will happen in terms of short-, medium- and long-term outcomes of the interventions, ToC seeks to overcome issues of attribution – Assists in the planning and implementation of an initiative – In-depth analysis of internal process issues – Multiple stakeholder involvement 	<ul style="list-style-type: none"> – External evaluation teams are rarely party to planning discussions in practice, so surfacing activities cannot take place at this point (Sullivan <i>et al.</i> 2002) – ToC suggests that all the theories and assumptions underpinning a programme be surfaced, but in practice, this can result in a number of differing realities being uncovered. ToC demands that one theory should prevail, but this is often not appropriate in practice – There are a number of practical difficulties in asking stakeholders to articulate such theories in the first place. Many find this an inherently difficult process 	National evaluation of Health Action Zones (Barnes <i>et al.</i> 2005); National evaluation of Local Strategic Partnerships (LSPs) (Office of the Deputy Prime Minister 2005).
RE	RE suggests outcomes are characterised by the equation (C) Context + (M) Mechanism – (O) Outcome. Pawson & Tilley (1997) argue that no individual-level intervention works for everyone, and no institution-level intervention works everywhere. RE seeks to discover which mechanisms work for whom, and within which contexts	<ul style="list-style-type: none"> – Overcomes issues of attribution by uncovering micro-level theory – Identifies which mechanisms work for which individuals, and in which contexts – Cumulative potential of knowledge of CMO configurations 	<ul style="list-style-type: none"> – Problems in identifying the outcomes of partnership working – Problems in identifying mechanisms; Pawson & Tilley (1997) suggest these are often microlevel psychological processes, but they have often been interpreted as grander programmes or theories in practice – Difficulties in conceptualising context (Calnan & Ferlie 2003; Dahler-Larsen 2001) – Difficulties in differentiating mechanisms from context (Byng <i>et al.</i> 2005) 	Evaluation of Health Education Authority's Integrated Purchasing Programme (I-HIPP) (Evans & Kiloran 2000)

(ToC) Theories of Change; (RE) Realistic Evaluation; and (CMO) context, mechanism and outcome

these approaches strengthen each other through their differing conceptualisations of what constitutes theory (Stame 2004); ToC searches for 'grander' programme theories whilst RE tends to be much more concerned with a micro-psychological level of theory.

Consolidation of these two approaches allows the involvement of multiple stakeholders, fulfils a developmental function, overcomes issues of attribution and also enables the identification of CMO configurations which may be of use in generalising knowledge across programmes. Therefore, the present paper suggests that this consolidated ToC and RE approach is the one that is most appropriate to the evaluation of health and social care partnerships. However, as previously noted, there are a number of difficulties in practice with both these evaluation approaches, and the present paper argues that their interpretation through a framework of CR may be a possible future path to strengthen this approach.

Critical Realism

While both ToC and RE are set within a realist philosophy, Julnes *et al.* (1998) suggested that the form of realism employed has a significant bearing on the emphasis of evaluation. The present paper suggests that setting these approaches within a different form of realist framework should overcome a number of the practical difficulties by which they have been beset. Critical Realism is not a methodology, but a philosophical endeavour (Kazi 2003) that, like RE, recognises the existence of generative mechanisms which combine to generate the flux of phenomena which constitute the actual status and happenings of the world (Bhaskar 1978).

This philosophy informs the kinds of questions put to reality and the manner in which this is done (Bhaskar & Lawson 1998). Critical Realism suggests that reality is made up of a stratified ontology, as demonstrated in Table 3. According to this, the domain of the real is greater and more encompassing than the field of the actual – which describes patterns of events. In turn, the actual is greater than the empirical – which describes the events we are actually confronted by and apprehend (Bhaskar 2002). Rather than the world consisting of one

flat ontological level (dubbed the 'epistemic fallacy'), as most partnership evaluations have tended to be, CR consists of a stratification of ontologies at differing levels.

Furthermore, CR recognises both the transitive and intransitive dimensions; where the transitive consists of the 'real' entities which make up the world, and the intransitive the knowledge or models we use to make sense of the real. This is where one of the strengths of CR lies for our purposes, in the ability to make realism compatible with epistemological relativism, particularly in relation to the social constructivist critiques which have been applied to ToC and RE.

Critical Realism maintains that, although generative mechanisms are not directly observable, they are nevertheless real and can be identified by a technique of retrodution. This is a form of iterative abstraction in which an argument 'moves from a description of some phenomenon to a description of something which produces it or is a condition for it' (Bhaskar 1986, p. 11). Essentially, RE is also a process of abstraction by which 'we move from one specific empirical case to a general theory and back to another case, and so on' (Pawson & Tilley 1997, p. 120). However, CR is a cyclical and continuing process: whenever a mechanism is uncovered, there are usually several others underlying it (Sayer 2000).

Within CR, all mechanisms are formed by an emergent process, much as they are within CT. Julnes *et al.* (1998) described this by an analogy of stacking dolls which are nested within one another. The difficulties in practicing RE in a health and social care context and identifying mechanisms were alluded to earlier in Table 2. Pawson & Tilley (1997), the originators of RE, suggested quite microlevels of mechanisms often relating to human choices and capacities. In these cases, it is the reaction of the individual to an aspect of a programme that is the mechanism, rather than the specific factor. The potential criminal does not commit car crime when closed-circuit television (CCTV) cameras are present because they fear being investigated as a result of being caught on camera, not simply because of the presence of the camera. Thus, the mechanism is not the CCTV camera, but the potential criminal's psychological reaction to the camera. This is seemingly a semantic separation, but has quite considerable implications in practice.

Evans & Killoran (2000) employed RE to evaluate the Health Education Authority's Integrated Purchasing Programme (HIPP), and suggested mechanisms such as local champions, partnership development work, formal project accountability arrangements and stakeholder events. Clearly, these mechanisms are quite different in nature to those suggested by Pawson &

Table 3 Ontological domains (Bhaskar 1978, p. 13)

Variable	Domain of real	Domain of actual	Domain of empirical
Mechanisms	x		
Events	x	x	
Experiences	x	x	x

Tilley (1997), which has implications for their generalisability; if the identified mechanisms are not 'true' mechanisms, but also part of the context, then the CMO configuration will not be able to be reproduced elsewhere to the same effect. Applying CR to this scenario would suggest that the mechanisms identified by Evans & Killoran (2000) are not incompatible with those which Pawson & Tilley (1997) proposed, but are situated at a different ontological layer. Byng *et al.* (2005) suggested that, when RE is applied in practice, mechanisms and contexts may not be entirely separable. This would be consistent with a CR framework, where these mechanisms are of a higher ontological level, thereby having multiple linkages with the surrounding open system and other mechanisms. Retroduction may be applied to these higher-level mechanisms to discover those of the lower-level micro-mechanisms.

Besides the concept of emergence, CR shares a number of other similarities with CT, particularly the conceptualisation of an open system (rather than the closed-container context that has been suggested to be represented by RE). Furthermore, CT suggests that the effects of an intervention may be a result of the fact that it was 'fortuitously' introduced at a particular point in time into a particular set of circumstances, such that it provided a catalyst for a step-change in the system (Sanderson 2000). Similarly, CR suggests that, when a system reacts in an unexpected manner, it may be because of deeply rooted ontological structures. The emergence of properties is brought about by deeply linking temporal and cultural factors, and these may not be assessed by looking at what is on the surface. This idea is supported in much partnership literature, where the importance of a good history of partnership working (temporal and socio-spatial ontological linkages) has been stressed as a success factor (Audit Commission 1998, Cameron & Lart 2003).

As previously highlighted, ToC provides a useful mechanism to gather programme theories from a range of stakeholders. However, the multiple realities which may be derived in practice may not be consistent with the version of scientific realism which RE employs. Pawson & Tilley (1997) went to great pains to dismiss the contribution that social constructivism can make to theory and the notion of the existence of multiple kinds of knowledge. Consequently, Bames *et al.* (2003, p. 274) suggested that evaluative approaches based primarily within a realist paradigm cannot sufficiently embrace the significance of contested meanings amongst multiple actors within such complex initiatives. However, as suggested earlier, CR attempts to bridge the ontologically real and the epistemologically relative, and as such, is capable of accommodating these multiple realities and addressing the criticisms of Social Constructivism.

Whilst Social Constructivist approaches would argue that categories (e.g. race, gender and class) are socially produced, CR recognises these as real. However, CR suggests that the ideologies and values which we ascribe to these categories are false – they are produced in the intransitive domain and, therefore, are fallible. What marks CR out as critical (i.e. with the potential to be emancipatory) is the concept that research can reveal the false values and ideologies ascribed to these categories. Bhaskar developed the Transformational Model of Social Activity (Bhaskar 1979) in relation to critical naturalism (his critique of the social sciences). In this, CR acknowledges the powers of social structures, but also the fact that such structures often presuppose our existence. Nevertheless, these social structures would not exist without our ongoing reproduction or transformation. Thus, there is a dialectical relationship between structure and agency, which would suggest that CR offers the possibility of incorporating institutional forces acting on individuals into the model. In studying and contrasting the empirical experiences of multiple stakeholders, the values and ideologies of these institutional forces may be exposed. Employing a CR framework facilitates the existence of multiple values, but CR then exercises judgemental rationalism, i.e. where it is still possible, in principle, to provide justifiable grounds for preferring one theory over another. Thus, we may surface all the underlying assumptions in an evaluation, but unlike ToC, this framework provides us with a means by which to deal with this multiplicity of stakeholder perspectives.

Interpreting RE and ToC through a CR framework can offer much in the way of overcoming a number of the difficulties which have been found in practice. Both RE and CR entail a search for generative mechanisms, but the open complex system that is modelled within CR may add much to the ability to search for and interpret mechanisms. Furthermore, CR offers a framework to explain the difficulties which have been experienced in attempting to differentiate between contexts and mechanisms and their linkages. What CR adds to ToC is an acceptance that all programme theory, of which there may be multiple interpretations, is formed in the transitive domain. Retroductive techniques may enable us to move from this transitive domain towards more closely modelling the intransitive. Furthermore, the fusion of epistemological relativism with ontological realism provides the opportunity to incorporate perspectives of Social Constructivism and Institutional Theory. Therefore, this framework offers the opportunity to build upon the evaluative advantages gained by incorporating ToC and RE. This is an approach that is currently being developed by the Health Services Management Centre, University of Birmingham,

Birmingham, UK, and it will be incorporated into an online resource that will further outline this method and house part of a new partnership evaluation tool (for further details, see www.hsmc.bham.ac.uk).

Conclusions

The present paper provides an overview of a wide range of approaches employed to evaluate health and social care partnerships. It suggests that method-led approaches to evaluations have proved to be insufficiently complex, and have largely failed to be able to overcome the ability to attribute changes specifically to partnership arrangements. Theory-led approaches seem better able to accommodate these complexities, and particularly, the combined use of a ToC approach and RE may prove the most fruitful to evaluate health and social care partnerships. However, such an approach is not without its difficulties, and a number of researchers who have tried to implement this in practice have encountered a number of conceptual and practical difficulties. The present paper argues that such difficulties may be overcome by interpreting ToC and RE through a framework of CR. It is proposed that the ontological stratification and separation of transitive and intransitive domains may be able to overcome difficulties, particularly relating to the conceptualisation and differentiation of context and mechanisms, and the accommodation of multiple perspectives.

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Evaluating the outcomes of health and social care partnerships: the POET approach

Helen Dickinson, Health Services Management Centre, University of Birmingham

Abstract

Health and social care partnership working is a central feature of the current government's approach to public policy. Yet despite this, and a proclaimed interest in evidence-based policy, partnerships have not empirically demonstrated that they produce better outcomes for service users. This is problematic because if partnerships are seen to have not delivered, this may result in the concept losing legitimacy in the eyes of the practice community. This paper argues that this may, in fact, be a result of the way in which we have attempted to evaluate partnerships – rather than an indication of the ineffectiveness of partnerships per se. After providing an overview of the various ways in which the 'partnership' label has been used in health and social care, the paper moves on to give an overview of the range of difficulties involved in evaluating partnerships. When it comes to evaluating partnerships the challenge is huge – but not insurmountable – and may involve us asking different kinds of questions about partnerships than have tended to be investigated thus far. The paper then moves on to outline POET (Partnership Outcomes Evaluation Toolkit) which has been specifically designed to determine what kinds of partnership deliver what forms of outcomes, to whom and when.

Keywords: Health and social care, partnerships, evaluation

Introduction

Since the New Labour government came to power in 1997, partnership working stands out as a *leitmotif* of their approach to public policy. Although it has long been recognised that, for particular issues and for certain individuals and communities with complex, cross-cutting needs, the co-operation of a range of agencies might be necessary to address these issues – partnerships have become ever more prevalent over the past decade. A range of policy documents have referred to the importance of health and social care organisations working in partnership (for example, Secretary of State for Health, 2000; Department of Health, 2005a; Secretary of State for Health, 2006) and the government has introduced a range of legal flexibilities (for example, The Health Act 1999) and mechanisms (such as Care Trusts, Children's Trusts, Local Strategic Partnerships, etc.) to encourage public sector organisations to work with others. In

recent years, the collaboration agenda has been further extended, beyond health and social care, to education, housing and welfare. Moreover, the most recent health and social care white paper *Our Health, Our Care, Our Say* (Secretary of State for Health, 2006) also indicates the importance of the involvement of commercial and third sector organisations in addressing a number of the key issues which today's society faces. Sullivan and Skelcher (2002, pp. 25-7) estimate that public sector organisations in the UK are involved in approximately 5,500 different partnerships and that these partnerships might have a total annual direct and indirect expenditure of between £15-20 billion. Whilst an estimate, rather than a precise calculation, and one which is now slightly dated, it cannot be in doubt that partnerships have a significant presence within the public sector.

The legislation which established the welfare state in the 1940s assumed that it was possible to distinguish between people

who are sick (that is, those who have health needs which are met by the NHS free at the point of delivery) and those who are frail or disabled (and are viewed as having social care needs, which fall under the remit of local authority social services and are often subject to means-testing for user charges). Despite a range of attempts to overcome this boundary, this underlying distinction still exists and has resulted in two separate agencies with different structures, priorities, financial systems, cultures and ways of working. This boundary continues to exist today and, although to some extent recent policy has become more sophisticated at hiding and blurring this divide, the government recognises that this boundary still causes significant difficulties for service users, particularly those who access services at times of significant stress or illness (Department of Health, 1998). Thus, partnership working has, to some extent, been seen as the mechanism to overcome the organisational complexities which are inherent within the current health and social care structures.

As well as being firmly wedded to the concept of partnership working, the incumbent government has also made extensive reference to the concept of evidence-based policy. Although evidence-based policy and practice is by no means a new phenomenon within health and social care (see Swinkels *et al.*, 2002), the present government has placed a particular emphasis on this concept. The Cabinet Office states in the Magenta Book (official guidance notes for policy evaluation and analysis), that “evidence-based principles are at the heart of the Government’s reform agenda for better policy making and policy implementation” (Cabinet Office, 2003, p. 17). Tony Blair himself has stated that “what counts is what works” and the government has been quite clear about its intentions to make policy according to what has been proven to work, rather than on the basis of ideological fiat – as the previous government was critiqued for. Given this

dual emphasis on partnerships and evidence-based policy, combined with a recent interest in user outcomes (expressed through such policy documents as HM Treasury, 2003; Department of Health, 2005b; Secretary of State for Health, 2006), it might be expected that partnerships have been empirically demonstrated to improve service user outcomes. Yet a number of evaluations of health and social care partnerships have consistently found little in the way of improved outcomes for those who use services (for example, Peck *et al.*, 2002; Brown *et al.*, 2003; Kharicha *et al.*, 2004; Townsley *et al.*, 2004; Davey *et al.*, 2005). Given the rhetoric about linking partnerships to improved service user outcomes and the central and local efforts that have gone into making a range of partnerships effective, for there still to be a lack of evidence demonstrating their impact for service users might be considered problematic to say the least. Moreover, a range of critical reports about partnerships have served to dent – if not completely destroy – credibility in this concept (see for example, Audit Commission, 2005; O’Hara, 2006; Community Care, 2007). The failure to evidence this way of working runs the risk of it losing legitimacy and professionals becoming disengaged from the partnership agenda.

This paper argues that this lack of evidence in part relates to the scale of the evaluation challenge, rather than a lack of demonstrable evidence *per se*. After defining the term partnership, outlining the scale of the evaluation challenge and the range of critiques which this concept has recently attracted, the paper goes on to provide an approach which is currently being developed and is intended to overcome these evaluative difficulties. The Partnership Outcomes Evaluation Toolkit (POET) is designed to determine what kinds of partnership deliver what forms of outcomes, to whom and when. Furthermore, POET is designed to offer a more nuanced view of the difficulties and challenges

associated with working in partnership and the sorts of support and development mechanisms which are necessary to support and overcome the complexities of working in collaboration.

What is partnership working?

As illustrated above, partnership working is not a new concept and to some extent is a necessary mechanism in order to overcome the structural difficulties associated with the existence of separate health and social care agencies. To this end, partnership is an important concept which aims to bridge the complexities caused by this boundary in terms of policy, practice and services for users. The UK is not alone in affording such a central role to the collaboration concept; in almost every country of the developed world there are problems of fragmentation and a lack of continuity in services for frail older people and other groups with complex, multiple needs (Banks, 2004; Glasby, 2004; Leichsenring & Alaszewski, 2004). Almost irrespective of language, culture, structure, context and funding, within most developed countries there are different services responsible for different aspects of service provision, often with different financial and regulatory systems, roles and responsibilities, and organisational and professional cultures (see Glasby & Dickinson, forthcoming). In pursuit of more joined-up services, a number of models have been developed to promote more seamless care for service users and more effective inter-agency collaboration. Therefore, although partnership is currently a key term within UK public policy, this is a reflection of a much wider phenomenon which is being experienced in many other parts of the world.

The term partnership is used to refer to a range of different forms of relationship or working arrangements within the health and social care arena. Leathard (1993, p. 5) identifies 52 separate terms which have been used to refer to 'partnership', a number

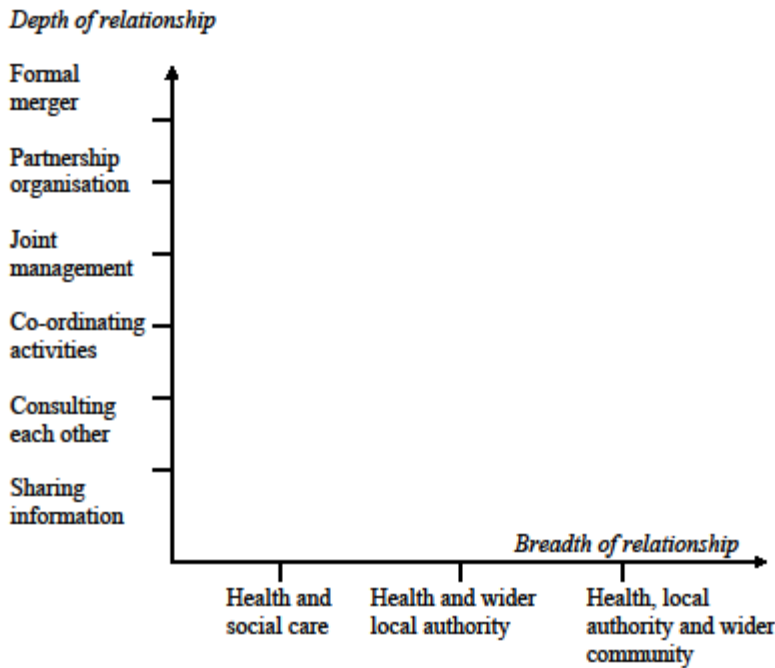
of which are often used interchangeably. No wonder then that she goes on to describe partnership as a 'terminological quagmire'. This plethora of terminology and imprecision of usage poses a potential difficulty, in that it can be problematic to establish what particular way of working is being specifically referred to when the term 'partnership' is used. Much of the established literature on inter-organisational relationships tends to suggest there are three ideal forms of relationship between organisations. These are most commonly referred to as markets, hierarchies and networks (Thompson *et al.*, 1991) although Ouchi (1991) speaks of markets, bureaucracies and clans, Bradach and Eccles (1991) of price, authority and trust, and Mayntz (1993) of markets, politics and solidarity. Rodriguez *et al.* (2007, p. 158) characterise these approaches as: rules (hierarchy); incentives (market); and, interactions (network). Each of these ideal types is thought to be optimal for governing interactions between organisations under different conditions and, consequently, each has different characteristics and behaviours. These ideal types are useful in predicting the behaviours of inter-organisational relationships. However, one of the difficulties with the partnership concept, as it has been used within recent health and social care policy, is that it has been used to refer to *all three* of these ideal types of relationship.

For example, we use partnership to refer to Care Trusts (which some would argue are effectively hierarchies), to Private Finance Initiatives (which are arguably market-based relationships) and to clinical networks (which relate more closely, if not entirely, to the ideal network form). Although we know each of these forms as partnerships, they are underpinned by different regulations and behaviours and, as such, we would expect very different outcomes to result from each of these arrangements. Although there are limitations to this idealised tripartite of inter-organisational relationships – and, in

practice, interactions usually exist as a hybrid or as several of these forms over a life-span (see also Lowndes & Skelcher, 1998) - this classification is useful in demonstrating the wide range of different entities known as partnerships within the health and social care arena. As Banks (2002) suggests, this can lead to a number of different forms being grouped together under the same term, when they may, in fact, be different (albeit perhaps only marginally so in some cases). In practice, what this means is that it is difficult to generalise the service user outcomes of partnerships, as partnership has been used to refer to so many different ways of working. Some commentators (see McLaughlin,

2004, for example) have suggested that it is this very lack of definitional clarity over the term partnership that has helped it become so popular. By being relatively broad and encompassing, the answer to any number of potential difficulties could be suggested to be 'partnership', and arguably it has been seen as such an answer in much health and social care policy over the past decade. One framework which is quite useful for characterising typologies of partnership relationships is illustrated in Figure 1. This framework can be employed to establish what types of relationships characterise a partnership and thus which partnerships are similar in nature.

Figure 1: Depth and breadth of partnership relationship (adapted from Peck, 2002)



The evaluation challenge

The range of definitions associated with the partnership concept is one of several evaluation challenges related to this way of working. As suggested above, partnerships may take a number of different forms and tend to be locally implemented, rather than existing in some centrally mandated form. Therefore, it is quite likely that each partnership will have slightly different aims and, consequently, different understandings of what constitutes success for that partnership. Moreover, as Dowling and colleagues (2004) note, the aims of partnerships are often similar to those of other public sector policies (i.e. improved efficiency and effectiveness). Therefore, demonstrating what it is *specifically* that partnerships aim to achieve outside of traditional modes of service delivery is difficult to establish. Thus, there is no single set of outcome indicators which can be used to assess whether a partnership has been successful. Drawing on evidence from the US, Schmitt (2001) suggests what is often missing from evaluations of collaborative efforts is an explanation of *why* certain outcome indicators were selected. In other words, outcome indicators have been selected but it has not been clear what the rationale behind this selection is, or how working in partnership should affect these indicators. As different types of partnership might aim to achieve very different things, it is important that the most appropriate outcome indicators are selected for that partnership – and these may differ from the outcomes another partnership is aiming to impact upon.

Furthermore, partnerships are often comprised of a number of groups who may have quite different perspectives of what it should achieve, and consequently of how the partnership should be evaluated (Thomas & Palfrey, 1996). Not only will different partnerships have different ideas of what counts as ‘success’, but it is likely that the stakeholders comprising that partnership

will vary in their opinion of what success will look like (see Barnes *et al.*, 2005, for an example of this in relation to Health Action Zones). Although partners should have some common goal in terms of the partnership, outside of this initial aim partners will likely have different agendas which they may not necessarily have shared with one another in their entirety. Failure to recognise different concepts of success leads to inappropriate conclusions about the effectiveness of partnerships, and potentially to the inappropriate application of research results (Ouwens *et al.*, 2005). Clearly, this poses a significant evaluation challenge when looking to generalise not only within a partnership but also between partnerships.

The contexts in which different partnerships exist vary widely and impact significantly upon the functioning of partnerships. In terms of learning lessons which may be applied within other contexts in the future, it is important to understand what it is about this context which has facilitated certain types of relationship. McNulty and Ferlie (2002) talk about the importance of ‘receptive contexts’ in terms of organisational change, and these contexts are similarly important for understanding what it is about certain partnerships which make them effective. As Pollitt (1995) illustrates, what works in one context may not apply within another, and as such it is important to understand the key features of particular contexts for these initiatives. An understanding of context is also important in another key way. Partnerships, like all policy initiatives, exist within broader policy environments which can make it difficult to demonstrate that it is this initiative specifically which has impacted on service user outcomes and not another. Indeed, the issues of attribution and causality are perhaps the largest challenges which partnership evaluations face, particularly given the breadth of outcomes which have been outlined in recent health and social care policy (for example,

Department of Health, 2005b; Secretary of State for Health, 2006). The interim report from the evaluation of Local Strategic Partnerships (LSPs) (Department for Transport, 2005, p. 17) suggests that it is difficult to demonstrate any clear outcomes of LSPs as the chains of causality are extremely complex. As such, the influence of partnership working may be subtle, indirect and cumulative – rather than a direct reflection of a programme. It could further be argued that this issue of attribution has become more complex under the current government, who in the early years of this decade, introduced a plethora of ‘initiatives’ (e.g. Health Action Zones, Sure Start, New Deal for Communities, Education Action Zones, Children’s Fund projects, etc.) which tend to have broadly similar aims and co-exist, often within socio-economically deprived areas.

Part of the difficulty with demonstrating causal links between partnership interventions and service user outcomes may stem from the fact that a number of the outcomes which partnerships are set up to address are often rather long-term in nature. For example, the national Sure Start evaluation (Wiggins *et al.*, 2005) found little in terms of impact of the programme in those areas targeted by the initiative – in fact some children were found to be worse off in the areas targeted by the scheme. There were a range of evaluative difficulties associated with this programme (for example, the population being quite mobile), but one key issue is that of timescales. Many of the targets that Sure Start is set up to achieve are long-ranging and it could be argued that we would not expect to see the real impacts until the children in these areas reach the latter half of their teenage years. There is a substantial difference between expecting to see changes take place within short (more politically acceptable) timescales of say three years in comparison with the 15 years plus which it might actually take to demonstrate change in practice. This poses a significant

challenge to partnership evaluations of this type – as it does to the evaluation of other policy initiatives. Moreover, many health and social care partnerships are increasingly being established with a preventative agenda. With the preventative agenda gaining increasing credence within recent policy documents (for example, Secretary of State for Health, 2006) a number of organisations are finding themselves grappling with the issue of how to prove that they have prevented something from happening.

This section has provided an overview of the predominant difficulties which may be encountered when attempting to evaluate partnerships, although, as suggested above, these are not all purely specific to partnerships but are encountered in most evaluations of complex policy initiatives. For the purposes of this paper, these tend to be the main difficulties reported within health and social care partnership evaluations – although there are others (for a detailed examination of the challenges in partnership evaluation see Glendinning, 2002; Dickinson, 2006). Clearly these difficulties are also contingent and will affect some environments more than others. However, what this section aims to illustrate is the scale and complexity of the evaluation challenge. Although, as previously outlined (and covered in more detail below), health and social care partnerships are yet to demonstrate that they appreciably impact on service user outcomes, this may in part be a reflection of the significant evaluation challenge associated with analysing these mechanisms rather than a lack of impact *per se*. This is reflected by Dowling *et al.* (2004) who, in an extensive search of the literature, found that there was little evidence documented about health and social care partnerships affecting service user outcomes and that the majority of partnership evaluations tended to focus on process rather than outcomes. That is, evaluations tend to look at how effectively partners are working together, rather than

whether working in this way necessarily impacts on the outcomes of those services.

This interest in process may partly reflect some tacit but ingrained assumption within the public sector (and evaluators' beliefs) that partnerships lead to better outcomes. Thus, rather than investigating service user outcomes, evaluators analyse the process of partnership working and, if this seems smooth, presume that positive benefits must be produced for service users. There is a fairly well-established literature which examines the main features that are necessary for the process of partnership to be effective (see for example, Wildridge *et al.*, 2004). This evidence is quite useful to draw upon, not least because central government has introduced a number of initiatives (such as the Health Act flexibilities, reorganising PCTs in an attempt to gain greater coterminosity with Local Authority partners) to mitigate the health and social care boundary. However, these have been largely at the structural and legal level as opposed to guidance to local health and social care economies about *actually* producing effective partnerships in practice. Such a view by government presumes that, by demolishing the structural and legal difficulties, local organisations should simply be able to create effective partnerships. When, in practice, as Armistead *et al.* (2007, p. 218) note, "partnerships are often overlain on a palimpsest of previous attempts at collaboration, which may betray a history of inter-organisational, interpersonal or clan conflict". As such, Glasby (2003) argues that three levels are essential in forming effective partnerships; structural, organisational and individual. These levels re-enforce each other, but all require attending to in the attempt to build effective partnerships. Whilst the government has been fairly attentive to questions of structure (such as legal and bureaucratic issues) it has been less so to organisational and individual matters – yet arguably these are the

challenges in which local health and social care economies require most support.

A number of partnership 'health assessment' tools, such as the Partnership Assessment Tool (Hardy *et al.*, 2003) and the Working Partnership (Markwell *et al.*, 2003) are available to assist partnerships by assessing the key features of effective 'process' in partnership working. These are generally cheap, quick and cost-effective, whilst designed to be generic and so applicable in a wide range of contexts. Critics have pointed out that, as useful as these tools are, they sidestep the issue of what partnerships might ultimately reasonably be expected to achieve; improved outcomes for welfare users (Rummery, 2002). These tools do not provide a comprehensive framework, and do not make explicit distinctions between inputs, processes and outcomes of successful collaboration (Asthana *et al.*, 2002). Many of these process assessment tools reflect this and point out that they are more useful as developmental aids, rather than as a means of central assessment (Hardy *et al.*, 2003; Halliday *et al.*, 2004).

A further reason for this evaluative focus on process over outcome, could be due to the fact that, as suggested above, actually choosing what outcomes to study is quite a complex task when thinking about multi-agency, multi-stakeholder entities like partnerships. When evaluating partnerships, it is insufficient to think simply of process, with little regard for outcomes; similarly it is insufficient to simply study outcomes with no consideration of the process of partnership working. Without understanding how effectively partners are working together, it will be difficult to know whether the expected outcomes should flow from the partnership. Partnerships are difficult to make work at the best of times (Hudson, 2006) and there are likely to be sticking points, which could potentially influence the impact which the partnership might have on services and, consequently, upon service

user outcomes. Thus, it is imperative that partnership evaluations can encompass both the process and the outcome of partnership working.

The POET approach to evaluation

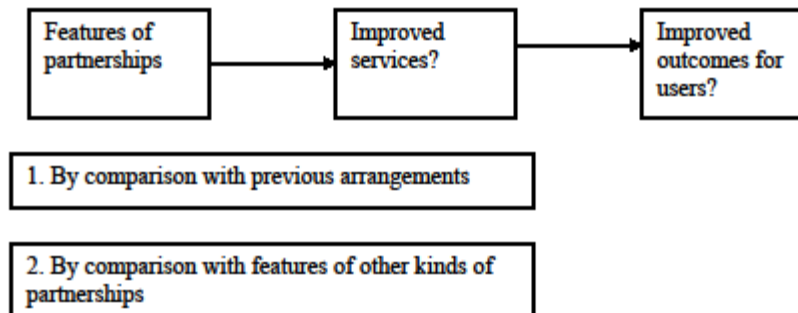
The government has expounded much rhetoric around the positive impact which health and social care partnerships should have on service users, but this has not been evidenced and, given the range of difficulties which a number of partnerships are presently experiencing, there is a danger that the concept will lose legitimacy and that front-line workers will no longer be prepared to engage with this agenda. Perhaps then, instead of asking “do partnerships improve outcomes of service users?” it is more appropriate to ask, “which service users do partnerships improve outcomes for, when, where and how?” Glasby *et al.* (2006, p. 373) characterise this question in Figure 2.

The Health Services Management Centre at the University of Birmingham has set up a project to test the question posed in Figure 2, producing the Partnership Outcomes Evaluation Toolkit (POET). POET is a generic toolkit (in that it can be used with a

range of health and social care partnerships that fit at different areas in Figure 1) designed to analyse both the process and outcomes of partnerships. This project aims not only to determine what sorts of service user outcomes are produced by different partnerships, but also offer a more nuanced account of how partners might work together more effectively and the sorts of support mechanisms this way of working demands.

As this paper suggests, in attempting to evaluate the outcomes of partnerships, it is insufficient to simply measure outcomes and compare these with previous results or those produced by similar contexts. Given the dynamism and complexity of partnerships as socio-cultural institutions, to only look at outcomes would miss the processes taking place within the ‘black-box’ of the partnership. With that in mind, POET takes a two-pronged approach consisting firstly of a staff survey and, secondly, of work with service users and carers. It is intended that, by combining these findings, a more rounded view of the partnership process and associated outcomes might be gained.

Figure 2 Effective partnership working (in theory) (Glasby *et al.*, 2006, p. 373)



Staff survey

The first part of the POET approach is to invite all, or at least a representative sample (depending on the size of the partnership), of staff members from all the partner organisations to complete a questionnaire. This part of the toolkit is based online which aids the speed of data collection, and all individuals are given a personalised user name and password which only they have access to. This means that all the information gathered in this survey is anonymous and non-identifiable and early indications show that individuals value this opportunity to be candid about their views. This survey has two distinct aims:

- Based on an extensive literature search on the process of partnership working, the survey aims to test the 'health' of the partnership. That is, this process is similar to the health assessment tools earlier referred to, and highlights the areas partners are working well together in and the areas where some developmental work might be necessary.
- As suggested earlier, partnerships differ in their aims and individual partners may also differ in their concept of what the partnership should achieve. In order to determine what outcomes should be analysed when evaluating a particular partnership, a 'Theories of Change' approach has been built into the staff survey. This theory-led evaluation method originated in the US (Connell *et al.*, 1995) but has recently been used in national evaluations such as the Children's Fund (Barnes *et al.*, 2006), LSPs (ODPM, 2005) and Health Action Zones (Barnes *et al.*, 2005). This approach aims to 'surface' the assumptions held by individuals within the partnership concerning what the partnership is aiming to achieve in terms of service users and carers. In other words, information is

gathered from all stakeholders about what success would look like for the partnership.

Once the data from staff members has been gathered and analysed, a 'health of the partnership' report is produced, illustrating staff perspectives of the partnership along with areas for celebration and development. This report also gives an in-depth view into the processes and contexts behind the partnership and how this might influence services provided by the partnership. Furthermore, this stage produces a range of information from all the stakeholders about what the partnership is aiming to achieve in terms of outcomes for those who use its services. Theory-led evaluative approaches are increasingly being used to overcome issues of attribution; this approach unlocks the 'black box', and looks at the processes which go on within the programme rather than simply at the outputs (Robson, 1993). This allows the researcher to then say with confidence which parts of the programme worked and why, whether they would be applicable to different situations and if there are any positive or negative effects which would otherwise not be anticipated (Birckmayer & Weiss, 2000). Rather than inferring causation from the input and outputs of a project, as experimentation does by excluding all other rival causal links, theory-led evaluation aims to map the entire process (Pawson & Tilley, 1997).

Service user and carer research

The second part of the research is very much informed by the first part. Therefore, although this is ostensibly a generic toolkit, it may be used within partnerships with quite different characteristics, but still be valid for that particular context. This part of the evaluation process takes the outcomes which were surfaced in the staff survey and forms a research schedule which:

- a. Checks with service users and carers whether these are the 'right' outcomes

that the partnership should be aiming to deliver. Are these what service users and carers value and are there any aspects which are missing?

- b. Verifies the extent to which the partnership is delivering on these particular outcomes.

As this process is determined by the context and nature of the partnership, this part of the evaluation process can look rather different from partnership to partnership. However, the outcomes which are expected to flow from partnerships would similarly be expected to vary, depending on the nature of the partnership. The toolkit provides guidance and examples exploring the different ways in which this stage of the evaluation might be carried out, and the kinds of approaches which are most appropriate for particular service user groups.

In this way, POET is both:

- *Formative* - it seeks to evaluate how well partners are working together, helps people to understand and make sense of their current context, and highlights both areas for celebration within the partnership as well as areas where development work is needed. It also allows partnerships to benchmark their performance and check back over a period of time to see if these issues have been resolved.
- *Summative* - POET is evaluative in that it requires partnerships to be explicit about desired outcomes and then analyses the degree to which the partnership is successful in achieving these aims.

POET is currently reaching the end of its initial testing and refinement stage, after which it will be launched nationally in conjunction with the Care Services Improvement Partnership. Although the initial testing is producing a series of key

lessons which seem salient across some of these sites, it is hoped that, once launched nationally, a much larger evidence base will be able to be captured. POET has been designed within a critical realist framework (see Dickinson, 2006, for further on the theoretical and philosophical underpinnings) which seeks to search for mechanisms behind observed phenomena. Such an approach acknowledges the complexity of the world, but argues that by using particular techniques, aspects of programmes or policies may be uncovered which tend to behave in particular ways under a set of specific circumstances. In this way, it is anticipated that POET will be able to offer generalisable lessons about what kinds of partnership are able to produce what sorts of outcomes, for whom, where and when – but also come up with best practice guidance relating to how to make partnerships more effective in practice and some support and development initiatives that might assist this process.

Conclusion

Health and social care partnership working is not a new phenomenon but, over the past decade, has received a particular focus from the New Labour government. Interest in this way of working has largely been predicated on the notion that it will improve services, and consequently outcomes for those who use services. Despite being a central feature of much health and social care policy over this period, and a range of mechanisms and initiatives which have been introduced to encourage and make the process of partnership working more 'smooth', there is still a lack of evidence to demonstrate that partnership working improves service user outcomes. Furthermore, in recent years, partnerships have been critiqued for their potential risks, and more recently there have been reports of partnerships coming under significant pressures. Partnership working is an internationally encountered phenomenon, and there are numerous reports from the UK and elsewhere of the damaging effects

which working in organisational silos can have on service users. Yet, a lack of evidence and current difficulties on the ground is leading to a crisis of confidence in this concept, which may lead to staff disengaging with this agenda.

This paper argues that it is the complex nature of partnership working and the scale of the evaluation challenge and the range of associated difficulties which this poses to evaluators which may prove to be the primary difficulty – rather than partnerships having a lack of impact *per se*. Rather than trying to establish whether partnerships lead to improved services for users, we should instead be investigating if partnerships do improve services, who is this for, where, when and how? Partnerships are difficult entities to make work and require much input. Although the government has introduced a series of mechanisms to aid this process, these have tended to be structural and legal fixes, rather than practical advice about how ‘to do’ partnership. Drawing on previous experiences of partnership evaluation, this toolkit aims to overcome these evaluative difficulties, incorporating both process and outcome evaluations. The POET project aims to offer a more nuanced account of partnership, offering practical advice on the kinds of support mechanisms and development opportunities which aid partnership working and the potential impacts different sorts of partnership might have, moving the debate to a more mature and subtle level concerning the ways in which health and social care services can be improved for the individuals receiving them.

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Notes on Contributor:

Helen Dickinson is a lecturer in health care policy and management at the Health Services Management Centre, University of Birmingham. She has a particular research interest in governance of health and social care services and the impact this has for those who use these services. As part of her PhD thesis Helen has designed POET which is an online resource which assists partnerships in evaluating their development and effectiveness.

Address for Correspondence:

Helen Dickinson
Health Services Management Centre
University of Birmingham
Park House
40, Edgbaston Park Road
Birmingham
B15 2RT

Telephone: 0121 414 7050

Email: h.e.dickinson@bham.ac.uk



Whose Outcomes are They Anyway? Report of the Pilot Evaluation of a Joint Service

Helen Dickinson

Jon Glasby

HEALTH SERVICES MANAGEMENT CENTRE, UNIVERSITY OF BIRMINGHAM

Robin Miller

SOUHL NHS CARE TRUST

Linda McCarthy

BIRMINGHAM AND SOUHL MENTAL HEALTH NHS FOUNDATION TRUST

ABSTRACT

Health and social care partnership working is often predicated on the notion that it improves outcomes for service users. Yet there is a lack of evidence linking partnerships to changes in outcomes. Against this background, the Health Services Management Centre at the University of Birmingham designed the Partnership Outcomes Evaluation Toolkit (POET) specifically to evaluate health and social care partnerships in terms of service user outcomes. This paper reports on the field testing of POET with Sandwell Integrated Support Service. This research provided a number of interesting insights into this service, and indicated some dissonance between staff and service user and carer expectations.

KEYWORDS: EVALUATING PARTNERSHIPS; OUTCOMES; CHILDREN'S SERVICES

Contact details: H.E.Dickinson@bham.ac.uk

Introduction

As has been well-documented, partnership working has been a central policy tool of the New Labour

administration since their election in 1997 (Glasby & Dickinson, 2005). This interest in partnership is particularly pronounced in the field of health and social care, where a whole range of policy initiatives and legal devolutions have been introduced to encourage more effective joint working. Health and social care partnership working is predicated on the belief that working together will improve services and consequently outcomes for those who use these services (DH, 1998). However, despite this interest and a frenetic pace of partnership-based activities, several commentators have noted that there is little empirical evidence that partnerships improve outcomes for service users (Evans & Killoran, 2000; Glasby & Leslie, 2004; Dowling et al., 2004; Learhead, 2005; Hudson, 2006).

Given this background, the Health Services Management Centre at the University of Birmingham designed the Partnership Outcomes Evaluation Toolkit (POET). POET was devised in order to assist health and social care partnerships to evaluate their work, particularly in terms of outcomes for service users. POET was field-tested with a number of sites in order to verify its usefulness and further to



develop this resource. The first site to test POET was Sandwell Integrated Support Service (SISS), which is a multi-agency service supporting children and young adults with special needs and/or disabilities from birth to the age of 25 and their families. This paper reports primarily on the findings of research undertaken with SISS, particularly in terms of the types of outcome which staff and families value, and then comparing them with those which are suggested in the wider literature.

Sandwell Integrated Support Service

SISS is composed of a number of teams which bring together professionals who are employed by health, education, social care and Connexions services. SISS was set up to bring together a number of the specialist teams working with children and young adults with special needs and/or disability into a single service. The purpose of bringing these individuals together is to ensure that their work is co-ordinated effectively and that the support they provide is based on the needs of the child or young adult and their families. SISS was set up in spring 2006, and the teams are based in the same building which provides a single public access in a physical location, complemented by a single phone number and email address. A number of services (for example Early Years and Parent/Carer Information and resource base) are provided on-site, but staff also visit children, young adults and their families in their own homes and community settings (such as schools and nurseries).

SISS is monitored and reviewed by the Service Management Group, which includes parents/

carers, local voluntary organisations and senior representatives from the agencies that have staff based in the integrated service. This group reports to the Children and Young People with Difficulties and/or Disabilities Sub-Group within Sandwell's Children and Young People's Strategic Partnership. It also links to the Learning Disability Partnership Board in relation to its work with young adults with a learning disability. The principles of SISS are outlined in Box 1, below.

Partnership Outcomes Evaluation Toolkit

As earlier suggested, POET is a resource, based partly on the Web, developed to assist health and social care partnerships to evaluate their work. It recognises the importance of both process (how well partners work together) and outcome (whether the partnership makes any difference to those who use services). As Dowling and colleagues (2004) note in their review of the literature on partnership research, much has been written about the way in which health and social care organisations work together and how it can be made more effective. Much of it has been embedded in partnership 'health assessment' tools, such as the Partnership Assessment Tool (Jenaby *et al.*, 2009) and the Working Partnership (Maxwell *et al.*, 2003), which are available to assist partnerships by assessing the key features of effective 'process' of partnership working. However, there is very little evidence demonstrating the types of service user outcome which health and social care partnerships specifically produce. As Dickinson (2008) notes, though, this lack of evidence does not necessarily

Box 1: SISS PRINCIPLES

- Children and young adults with special needs and/or disability have the right to be supported to participate in family and community activities and facilities
- Children and young adults have a right to achieve their full potential
- Services should be organised around the needs of children, young adults and their families
- Children, young adults and their families are actively involved in all decisions affecting them and in shaping local services
- Parents need support as carers of a child or young adult with a special need or disability and have a right to a fulfilling life
- Services will be sensitive to the cultural needs and requirements of children, young adults and their families and will work with them to address discrimination positively



mean that partnerships are ineffective. Partnerships are incredibly difficult to evaluate (Clerdinning, 2002; Hudson & Hardy, 2002), and it may be that we do not have this evidence because we have not yet managed to evaluate these entities effectively in terms of service user outcomes.

The range of definitions associated with the partnership concept is one of several evaluation challenges related to this way of working. Partnerships may take a number of different forms, and tend to be implemented locally, rather than existing in some centrally mandated form. It is therefore quite likely that each partnership will have slightly different aims and consequently different understandings of what constitutes success for that partnership. As Dowling and colleagues (2004) note, the aims of partnerships are often similar to those of other public sector policies (for example improved efficiency and effectiveness), so demonstrating what it is specifically that partnerships aim to achieve outside traditional modes of service delivery is difficult. Thus, there is no single set of outcome indicators which can be used to assess whether a partnership has been successful.

Drawing on evidence from the US, Schmidt (2001) suggests that what is often missing from evaluations of collaborative efforts is an explanation of why certain outcome indicators were selected. In other words, outcome indicators have been selected, but it has not been clear what the rationale behind this selection is, or how working in partnership should affect these indicators. As different types of partnership might aim to achieve very different things, it is important that the most appropriate outcome indicators are selected for that partnership – and these may differ from the outcomes another partnership is aiming to achieve. Investigating the types of outcome which health and social care partnerships are specifically set up to achieve is therefore a key feature of the POBT process.

Dickinson (2006, 2007) provides a more detailed overview of the POBT approach. Given that the focus of this paper is on the results of the

evaluation, we outline briefly this process here before giving details of how it was conducted in this research. POBT essentially consists of a two-pronged approach:

- involving all staff members to complete an online survey which analyses how the partnership 'feels' to them and surfacing all the underpinning assumptions about what the partnership is aiming to achieve in terms of outcomes for service users;
- using the information from the staff survey, designing a research schedule which checks with service users and carers whether these are the 'right' outcomes to be aiming for, and the degree to which the partnership has been successful in changing these outcomes.

In this way, POBT is both:

- formative, because it seeks to evaluate how well partners are working together, helps people to understand and make sense of their current context, and highlights areas for celebration within the partnership as well as areas where development work is needed;
- summative, because POBT is evaluative in that it requires partnerships to be explicit about desired outcomes and then analyses the degree to which the partnership is successful in achieving these aims.

After a workshop which explained the purpose of the research, all staff members were invited to complete the online assessment ($N = 73$), which is anonymised and accessed by individual confidential user name and password. Of the invitations sent out, 52 were completed and submitted (69% completion rate), but five of these were not sufficiently completed to be used. In terms of usable returns, this equates to 46 completed questionnaires (61%). A report was produced for SSS, presenting back the 'process' based findings, and an overview was provided to teams at a workshop. The outcomes which staff members suggested that the integrated team was set up to achieve were also presented back to the staff, and they conducted a



group exercise to discuss them further and narrow them down to a more concise list.

After the workshop, all the families who had recent contact with SSS were sent a postal questionnaire which was informed by the findings of the first phase of the research. This survey had three substantial sections covering the experiences of the families in terms of the support they received from SSS, which of the outcomes identified by staff members families valued and would prioritise in the services they receive, and perceptions of any barriers that they have faced when trying to access services. This questionnaire garnered a response rate of 10% which, although relatively low, is comparable with rates of return in other research projects where unsolicited postal questionnaires have been used (Oppenheim, 1992). A further report was produced, setting out these findings, and was followed by seven semi-structured interviews with families (which were tape recorded and transcribed) to investigate further the outcomes which families privilege and value in services in more detail.

The findings of this process are set out, below in more detail, before moving on to reflect on the implications in relation to the wider health and social care partnership literature.

Findings

Online survey

In response to the first stage of the research, staff were on the whole very positive in their views of how well to work within the integrated service. Most of the process issues which are highlighted as imperative to partnership working in the academic literature seemed to be present and fully well-developed in this service. A number of people stated clearly that they enjoy working in an integrated team, with the opportunities it affords to advance their professional learning and support children and families better. The main issues highlighted in terms of working together related to feelings of ownership of the integrated service and whether a specific culture had been forged but,

given the early days of the service, these issues went to a certain degree, anticipated.

Although staff members found it relatively simple to respond to the more process-related questions, outlining the types of outcome the service was set up to achieve proved more challenging. From the outset the research team had anticipated that the process of surfacing the outcomes which the integrated team was trying to achieve would be difficult. Respondents had agreed strongly in previous questions that SSS has clear aims and objectives for the organisation. However, actually articulating this in terms of service user outcomes posed difficulties for some respondents. This may be due partly to the fact that the guidance might have needed further development, but also because it is a fundamentally difficult task (and other sites where INDET has been used have encountered similar problems).

Many of the outcomes identified were aspirations for the future rather than things currently being worked towards. Again, though, this may be a reflection of the early stage that the integrated service was at. A number of outcomes tended to be more orientated to organisational aspirations than service user aspirations – although in a number of cases one could see the logical progression from these towards better services for families and children. For example, 'creating an integrated IT system' was one service user outcome stated by several respondents. Although an integrated IT system might make it easier for staff to interact with one another and, as a consequence, could improve outcomes for children and young people and their families, this is an organisational outcome rather than a service user outcome. As outlined above, given the difficulties with this process, outcomes were discussed further in a workshop with staff members where small group work was done to develop them further. The end list, which staff agreed they were trying to achieve is outlined in Box 2, opposite. This is a list of aims and aspirations for the service rather than necessarily service user outcomes, which illustrates the difficulty which the staff members had with



this process (and we reflect on this further in the discussion section).

Box 2: OUTCOMES SUGGESTED BY SISS STAFF

- Being treated with kindness and care
- Easy access on the telephone
- A welcoming building
- Services responding quickly
- Information being passed to all or services only with our agreement
- Being able to tell our story once and not repeat it
- Knowing how to get help from other services
- Being asked about changes in services
- Having the support we will get written down for us
- Being given the option of home visits
- Having one professional to co-ordinate our support

Postal questionnaire

The families who responded to this survey were largely very positive about the services that they receive in relation to a broad set of individual statements. Interestingly, in the free text sections some of the responses outlined resonated with staff opinions about the length of time it took for the team to 'get going', but suggested that now it had been operational for a while it was working much better. The outcomes in *box 2* were presented to families to check whether they agreed that they are

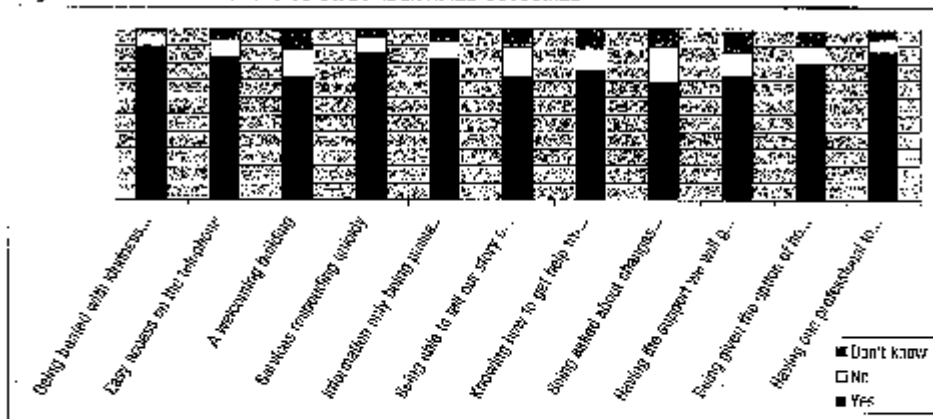
all important in service delivery. Again the responses were positive in relation to these statements (*Figure 1*, below). Perhaps this could be expected to a certain degree, since many of the statements are probably difficult to disagree with (such as wishing to be treated with kindness and care). However, these were the outcomes identified by the staff members, and they clearly, albeit to differing degrees, resonated with families. The survey also asked about factors inhibiting access to services, and this was the section which got the most mixed responses from families. Interestingly, a number of the barriers which staff members highlighted as causing difficulty were not identified by families in the same manner (particularly in terms of access and parking at the integrated team site).

Overall, the responses from families seem largely positive. However, these are just a snapshot representation of families using the service who are responding to pre-determined statements and priorities, so semi-structured interviews were undertaken to investigate these factors in more detail.

Interviews

A psychologist who was based in the integrated team (IMAC) undertook the interviews. Given her familiarity with the families and setting, it was

Figure 1: FAMILY RESPONSES TO STAFF-IDENTIFIED OUTCOMES





telt that she would be able to establish a better rapport than external researchers from a university. After taking some initial enquiry questions relating to the contact that they had had with the teams, interviewees were presented with a sheet with an extended list of outcomes which had been suggested by staff members in the earlier phases of the research. Interviewees were asked to identify which of these they thought were most important, which were not important and whether there were any which were not on the list but were perceived as being important. The added value in terms of the semi-structured interview approach was that follow up questions could be asked to investigate these preferences and perceptions in more detail.

Again, responses from interviews were very positive in terms of SSS, and families suggested that they were receiving good-quality services. Families outlined that keyworkers play a crucial role in providing a single and consistent point of contact, which is very highly valued. The biggest difficulties which families seemed to be facing were access to and knowledge of a wide range of services – most had contact with an incredibly wide range of services. This concurred with what staff had suggested in the survey. Staff and family opinions did, however, contrast in relation to a couple of issues relating to the facilities and appearance of the building that hosts the service and the need to repeat information a number of times. Staff suggested in the survey that they felt that the quality of facilities were poor and that this was having a significant impact on the services offered to families, but families cited this as not a major issue and of little concern. According to the (then) manager of SSS, staff had long had complaints about the building and parking facilities, and in this case had seemed to suggest they had a significant impact on service users – even though this perception was not shared by families. Indeed, the majority of families interviewed did not visit the site where the team was housed frequently, and instead received home visits from their keyworker.

It is frequently suggested in the wider partnership literature that service users are often reluctant

to repeat information to professionals (Audit Commission, 1998). In this case families seemed to suggest that this was not at all a concern. Given that circumstances change quite quickly as children grow up, a number of parents felt it necessary to be able to give information fairly often, while others said that it could even be quite therapeutic to be able to talk regularly about their circumstances.

Discussion

Partnership working is often predicated on the notion that it will make services easier to access and less complex for those who use them. This seemed to be largely the experience of the families who were receiving services from the integrated team, who reported that this was in large part a consequence of the role of the keyworker. However, an important point to note – and one which is less considered in this discussion – is that, although this makes access easier for service users and their families, essentially it internalises the organisational complexity and makes it less visible to people accessing these services – but it exists nonetheless. Staff members need specific support mechanisms in place to help them deal with this organisational complexity, and recognition that it does not simply go away.

Glendonig and colleagues (2006) undertook research into the types of outcome which older people value. This is not distinguishing between three different types of outcome:

- those involving change (for example physical functioning, morale, behaviour)
- those involving maintenance or prevention (such as safety, cleanliness, physical needs)
- service process outcomes (for example being valued, having a say in services, respect for cultural preferences).

Interestingly, most of the outcomes that appeared to be important to families related more to service process outcomes than to change or maintenance outcomes. Clearly the research undertaken here tended to involve the opinions of carers much more than those of the children and young people themselves, and these findings concur with work



undertaken with carers in other settings (Miller et al. 2008). It's also underlines the importance of the relationship between those operating in the role of keyworker and the families of the children and young people.

One important factor which became apparent from the interviews was that the difficulties which families were facing often arose because they could not access other teams or services which fell outside the remit of the integrated service. This seemed to be a clear illustration of one of Walter Leutz's (1999) 'five laws of integration: 'your integration is my fragmentation'. If partnerships of this type are about co-ordinating services around the needs of children, young people and their families, then there's clearly an important role in deciding which teams come within the boundaries of the service and which sit within a wider partnership. Although Leutz's warning might be true, his first law –

you can't integrate some of the services for all of the people, or all of the services for some of the people, but you can't integrate all the services for all the people.

also needs to be taken into consideration in practice.

It is often suggested that partnership working exists on some form of continuum, such as Hudson and colleagues' (1997, 1999) 'framework for collaboration', which is a continuum of 'isolation, encounter, communication, collaboration and integration'. Isolation is a situation where there is a total absence of joint activity, while integration is a point where there is so much collaboration that the separate identities of the organisations are insignificant. In talking about the integrated service, it may be useful to define which families the services with which they need close links and therefore close relationships, and those with which they need links but ones which take a different form.

What is interesting from the research undertaken here is the dissonance between what some partners seem to see as the primary purpose

of the partnership and what families suggested they wanted from integrated services. This is an interesting point, given that central government has not been very specific about what partnerships should achieve, other than that they are a 'good thing' that will improve service user outcomes in some way. It is not altogether surprising that staff were unable to articulate service user outcomes, given that central and local policy has not been explicit about them either. Local staff were able to articulate this term and use it to frame issues which were of concern to them in this language of service user outcomes. In other words, as it has not been stated explicitly what, specifically, partnerships are supposed to achieve, this term (and the associated language of service user outcomes) can be appropriated to make these changes seem more appealing. After all, who could argue against partnership?

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**‘Why partnership working doesn’t work’: pitfalls, problems
and possibilities in UK health and social care**

Jon Glasby and Helen Dickinson

**Health Services Management Centre
University of Birmingham**

Address for correspondence

Jon Glasby
Professor of Health and Social Care
Health Services Management Centre
University of Birmingham
Park House
40 Edgbaston Park Road
Birmingham
B15 2RT

0121 414 7068

J.Glasby@bham.ac.uk

‘Why partnership working doesn’t work’: pitfalls, problems and possibilities in UK health and social care

Abstract

Since the election of a New Labour government in 1997, UK public services in general (and health and social care in particular) have become increasingly dominated by the notion of partnership working. Despite this, more recent years have seen something of a reaction against partnerships, with a growing number of policy, practice and research commentators starting to question whether partnership working remains a credible concept, whether it achieves outcomes that other ways of working cannot, and whether this justifies the energy and upheaval which partnership working often entails. Against this background, this paper reviews lessons learned from a case study forensic mental health partnership, arguing that the service in question reveals a number of common pitfalls in terms of the way that partnerships are established and put into practice. In many ways, this was not the fault of the case study partnership, but the product of the wider institutional context in which health and social care partnerships have been developed and promoted. Ultimately, the paper concludes that the current concept of partnership working may be losing credibility because of such pitfalls, but that this remains a potentially important way of working that still has something to offer.

Key words:

Health and social care

Partnership working

Inter-agency collaboration

‘Why partnership working doesn’t work’: pitfalls, problems and possibilities in UK health and social care

Background and introduction

In recent years in the UK, the concept of partnership working or inter-agency collaboration has arguably gone from being flavour of the month to yesterday’s (largely discredited) bright idea. Since the election of a New Labour government in 1997, partnership has become a core feature of UK social policy, with new inter-agency funding streams, policy initiatives and organisational structures across most areas of the UK welfare state (see, for example, Balloch and Taylor 2001; Glendinning *et al.* 2002; Sullivan and Skelcher 2002; 6 *et al.* 2002, 2006). As an example of the growing importance of partnership working, the word ‘partnership’ was recorded 6,197 times in 1999 in official parliamentary records, compared to just 38 times in 1989 (Jupp 2000: 7). When Author A and B (2008a) repeated this exercise more recently, they found that there were 17,912 parliamentary references to ‘partnership’ in 2006 alone (although this falls to 11,319 when references to legislation on civil partnerships were removed). Throughout this process, the rationale for New Labour has been clear. As the Department of Health (1998: 3) set out in an early discussion paper, *Partnership in Action*:

“All too often when people have complex needs... good quality services are sacrificed for sterile arguments about boundaries. When this happens people, often the most vulnerable in our society... and those who care for them find themselves in the no man’s land between [current services]... This is not what people want or need. It

places the needs of the organisation above the needs of the people they are there to serve. It is poor organisation, poor practice, poor use of taxpayers' money – it is unacceptable.”

In practice, more neutral commentators have argued that the current emphasis on inter-agency working may be more a product of a desire to counter the fragmentation caused by previous market reforms in public services and a response to changing demography, public expectations and social circumstances (see, for example, Author A and B 2008b). However, the fact remains that inter-agency working has increasingly become a core feature of UK public services, rather than an optional extra.

While this is true of most public services, it is particularly the case in health and social care, with repeated commitments to bringing down what is often described as ‘the Berlin Wall’ between health and social care. Despite many changes, the UK system is still based on the assumption that it is possible to distinguish between people are ‘sick’ (who have health needs met free at the point of delivery by the NHS), and people who are merely ‘frail’ or ‘disabled’ (who are seen as having ‘social care’ needs that fall under the remit of means-tested local authority adult social services). As many people using or working in health and social care services know, this distinction rarely seems meaningful in practice, and a raft of recent policy has sought to create more integrated or ‘seamless’ care, where the boundaries between services are not perceived as a barrier from the perspective of the service user.

Despite the growing emphasis placed on inter-agency collaboration, more recent years have witnessed something of a backlash against the concept of partnership working. From the early days of New Labour, several external commentators began to express their concerns about the lack of precision with which the term ‘partnership’ is often used (see, for example, Banks 2002: 5):

“The term ‘partnerships’ is increasingly losing credibility, as it has become a catch-all for a wide range of concepts and a panacea for a multitude of ills. Partnerships can cover a wide spectrum of relationships and can operate at different levels, from informally taking account of other players, to having a constructive dialogue, working together on a project or service, joint commissioning and strategic alliances.”

In 2005, moreover, the government’s Audit Commission published a strongly worded critique of partnerships, arguing that this way of working did not always deliver value for money, could sometimes cause confusion and hence weaken accountability, and could pay insufficient attention to issues of leadership, decision-making, scrutiny and risk management. Above all, the Audit Commission (2005: 2) claimed, “local public bodies should be much more constructively critical about this form of working: it may not be the best solution in every case.” That this is indeed the case has been demonstrated over time by a series of reviews of the partnership literature, all of which conclude that the vast majority of research to date has focused on issues of process (‘how well do we work together?’) not on outcomes (‘what difference does this make?’) (see, for example, Cameron and Lart 2003; Dowling *et al.* 2004). Even where a very small minority of studies have attempted to consider outcomes, the results have often been ambiguous and it has been unclear what kinds of impact

should be attributed to partnership working *per se* (as opposed to other changes in the study areas) (see, for example, Peck *et al.* 2002). As Powell and Dowling (2006: 305) suggest, partnership working represents “the undefinable in pursuit of the unachievable” – while “there is no shortage of advice on how to ‘do’ partnerships... with lists of drivers, building blocks, and components..., the validity and reliability of this input into ‘evidence-based’ policy making is less clear.” As Dowling *et al* (2004: 315) conclude:

“The present authors’ search of the literature has revealed the rudimentary state of the art of conceptualising, measuring and demonstrating the success of partnerships... [Of studies included], only a few investigated whether specific partnerships had produced successful outcomes and the results were ambiguous even in these... Thus... knowledge of whether partnerships ‘work’ – in the sense of producing benefits to those who pay for, provide or use services – remains very limited.”

In a number of ways, such findings seemed to strike a cord with many front-line services, who were increasingly finding it difficult to work across agency boundaries, and were starting to ask themselves if current partnerships were always worth the effort. The reality is that working in partnership is often a difficult and complex process, requiring much investment (of time and sometimes of financial resources) and as illustrated above, seemingly little return. Such a view gained added impetus from a series of local health and social care scandals in areas such as Barking, Wiltshire and Cornwall, where longstanding partners were claimed by the national media and the trade press to have ‘fallen out’ with each other and, sometimes, have

begun to dismantle previous partnership arrangements (see, for example, Batty 2003; Healthcare Commission/Commission for Social Care Inspection 2006; O'Hara 2006).

Against this background, our consultancy and development work with national policy makers and with local health and social care communities has led us to the conclusion that current attitudes to health and social partnerships (and to partnership working more generally) are more healthily sceptical than before. However, this experience of working both with policy and with practice has also prompted us to identify a series of common errors which those who espouse the potential benefits of partnership working often seem to make when developing and implementing policy and strategy. Building on a case study partnership recently evaluated by the present authors, the remainder of the paper seeks to explore these errors in more detail. While the agencies involved seemed genuinely to be attempting to improve services, the partnership in question nevertheless seemed to us to provide a practical illustration of everything that is currently wrong with the over-emphasis and uncritical acceptance of partnership working. Despite the slightly provocative nature of our title, we do not believe that partnership working *cannot* work (indeed, elsewhere we have argued that partnership working seems an intuitively helpful approach in some settings and that the lack of evidence concerning the outcomes of partnership working may be more to do with the limitations of current research rather than with the concept of partnership itself; see, for example, Author's own 2006, 2008a, 2008b). Instead, we believe that current misunderstandings about the nature and the potential of partnership working mean that many partnerships are designed in ways which mean that they are unlikely to meet the (very high aspirations) of those who form them (i.e. not that they *cannot* work, but more that they often *do not* work, for some of the reasons outlined below).

The case study¹

The case study adopted in this paper to illustrate some of the pitfalls of partnership working began as a relationship between two mental health provider trusts.

Springfield Mental Health Trust (not its real name) is a nationally and internationally renowned organisation, well known for its specialist forensic services and seen as one of the leading providers of its kind in the UK. It is financially robust, frequently seen as a national expert on key mental health issues and very aware of the status and prestige which it enjoys locally and nationally. It also has a central location within the city where it is based, and its specialist status means that service users often travel substantial distances to receive treatment within the Trust. In contrast, Shelbyville Mental Health Trust has virtually no forensic expertise, provides a much broader range of more local, community-based services, and covers a much smaller catchment area. It is based out of town at some distance from Springfield, and has previously received negative reports from health care inspectors about some aspects of the quality of care it provides.

Two years ago, Springfield and Shelbyville formed what they described as ‘The Forensic Mental Health Partnership’ or FMHP. Shelbyville staff working in forensics transferred their employment to Springfield who became the lead partner managing the overall forensic service provided at both sites. From the beginning, this was presented to staff, to service users and to external stakeholders as a ‘partnership’, and

¹ While based on a real-life case study, this paper has changed a number of practical details about the partnership concerned in order to maintain its anonymity.

the two organisations were keen to emphasize that each had much to learn from the other – Shelbyville benefiting from the expertise, resources and reputation of Springfield, and Springfield learning from Shelbyville about the skills and approaches required to work with people with lower-level needs in the community.

Keen to understand the impact of this new arrangement, Springfield commissioned an early evaluation of FMHP, with external researchers carrying out individual interviews, holding focus groups and running an online consultation with all levels of Partnership staff to explore the outcomes which FMHP had been set up to achieve, the drivers behind this and the extent to which the Partnership had been successful. As a result of this process, it quickly became apparent that neither Springfield nor Shelbyville felt that this was ‘a partnership’ at all, and FMHP was described by all as a Springfield ‘takeover’. While most Springfield staff and some Shelbyville managers were generally content with this state of affairs (and indeed suggested that more honesty was needed so that everyone knew it was a takeover), many members of front-line staff at Shelbyville felt that FMHP really should be a partnership of equals (regardless of the fact that Springfield directly manages a proportion of Shelbyville staff), and that Springfield really did have as much to learn from them as they did from Springfield.

Despite these aspirations, most staff from both ‘partners’ felt that the way in which FMHP had been established and carried out its subsequent work reinforced a sense of a Springfield ‘takeover’. Although the partnership spanned two sites, most meetings and training took place at Springfield, and Shelbyville staff were typically expected to travel some distance to come to Springfield (rather than the other way round). The

board established to oversee the partnership was dominated by Springfield members of staff, and the Shelbyville senior management team were felt to have disowned forensic services now that responsibilities had been delegated to the partnership. Given a leading role for Springfield, moreover, many participants felt that the procedures, approach and culture adopted by FMHP were all Springfield-dominated.

When asked what the partnership had been set up to achieve (in terms of outcomes for service users), there were a number of key trends evident in staff responses:

1. First and foremost, many staff (at all levels within the partnership) found it hard to identify what FMHP had been set up to achieve. This was partly because some of them had never been asked before, but also because there was no single, clear statement of the outcomes which the partnership was trying to deliver. While some previous internal policy documents set out process-based aspirations (such as having single point of access for service users), these were often very unspecific (for example, 'reducing duplication') and often focused on processes and outputs rather than on outcomes (see below for further discussion). Indeed, despite detailed questioning, the partnership ultimately found it impossible to say what it was trying to achieve (or why this form of partnership may be a good way of going about delivering these outcomes).
2. After further consideration, desired outcomes identified by participating staff were primarily organisational in nature (rather than centred on the needs of service users). While staff would normally claim that the partnership was meant to provide better services for users (often in a very unspecified way), the bulk of the

potential benefits that they cited were mainly to do with a more efficient use of scarce organisational resources (such as a single point of access, preventing duplication, simplifying policies and procedures etc.) Although these might lead to better services in time, the overriding impression from staff was that FMHP was designed primarily to benefit partner organisations. The closest that staff could come to articulating an overall vision for service users was to suggest that FMHP might enable people to get access to more responsive mental health services closer to home, and therefore to lose fewer days of employment through mental ill health.

3. Where potential benefits for service users were suggested, these tended to be very diverse and very aspirational (often without it being very clear why a partnership of any form might be expected to achieve these things). Examples included a desire to deliver more cost-effective services, closer to home in a way that empowers service users, respects their individual needs and meets all cultural and linguistic needs (in a very multi-cultural community). As discussed below, staff who initially found it hard to identify desired outcomes very quickly began to contemplate a series of arguably over-ambitious aims and objectives once they began to talk in detail about FMPT.
4. After detailed discussion in interviews and focus groups, it quickly became apparent that part of the initial motivation for FMHP had come from senior managers in both organisations trying to respond to local and national politics. At the time the partnership was first discussed, Shelbyville had recently experienced an extremely high profile mental health homicide, and a very critical serious case

review was expected shortly. Also at this time, the region was reviewing the current configuration of mental health services, and Shelbyville was one of the organisations rumoured to be at risk of closure or merger. Although not directly affected by either the homicide or the reorganisation, Springfield was nevertheless fighting hard to throw off a reputation for being too aloof and autocratic, arguing that it should be at the centre of a regional mental health system (at the centre of a hub and spoke model). Against this background, FMHP was a timely development, as it gave important messages to national policy makers that Shelbyville was dedicated to improving its services and that Springfield was working hard to be a more collaborative member of its local and regional health community.

5. Once the initial decision to develop a new relationship was announced by senior managers, it was presented to front-line staff as a 'partnership' and justified in terms of potential benefits for patients. Because it began life as a top-down measure, however, staff felt that it had taken a long time for practical operational systems to be developed to support the work of FMHP. Thus, there were ongoing disagreements and a lack of clarity over issues relating to finance, HR and estates – almost as if wider support services in both organisations had not yet caught up with the initial policy announcements of the respective management teams.

Common pitfalls

As argued above, we believe that the example of the Forensic Mental Health Partnership illustrates a number of common themes in the partnership literature and in

front-line health and social care practice. In particular, we have identified six main issues:

- The failure to identify desired outcomes (with the subsequent risk that the partnership becomes an end in itself rather than a means to an end).
- Calling the new entity a ‘partnership’ (arguably in an attempt to make it sound less like a ‘takeover’).
- Despite claiming that the partnership was meant to provide better services for patients, the real intentions of the partnership seemed to be (initially at least) organisational in nature.
- In addition to stated aspirations, the partnership was motivated in part by a series of unstated drivers (in this case, local and national politics).
- The tendency to see partnership working as a panacea to a series of current problems, placing too much faith in its ability to deliver a series of over-ambitious aspirations (therefore running the risk of disillusioning staff if such aspirations are not achieved).
- Undermining the subsequent partnership by failing to attend to practical details.

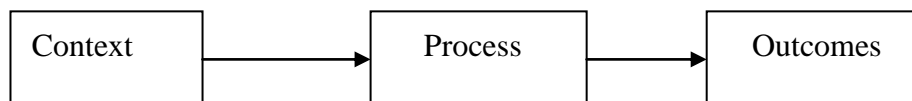
Against this background, the remainder of the paper considers each of these in turn, before going on to discuss these findings and investigate whether these pitfalls are to

some degree inevitable given the nature of the health and social care institutional context.

Not being clear about outcomes

In our view, partnership working should only ever be a means to an end (of better services and hence better outcomes for service users). By failing to be clear about desired outcomes, managers and policy makers run the risk of turning partnership working into an end in itself (such that having a partnership becomes the main aim). To guard against this danger, front-line services would do well to pose themselves a series of challenges before, during and after exploring the need for a partnership. At its most fundamental, services can ask a simple but crucial question: if partnership working is the answer, what is the question? In a more sophisticated version of the same underlying issue, services can break their thinking down into three different stages (see figure 1):

Figure 1 Focusing on outcomes



Source: Author A and B 2008a

Drawing on approaches common in realistic evaluation and theories of change (Connell and Kubisch 1998; Pawson and Tilley 1997 respectively), this framework prompts services to ask:

- What are they trying to achieve for local people (outcomes)?
- How well do single agencies do this at present (context)?
- What needs to change and how in order to get from where they are now to where they want to get to (process)?

Crucially, such an approach prevents the partnership from becoming an end in itself, gives a clear and shared sense of what success would look like, ensures that there is a joint understanding of current problems to be tackled and provides some success criteria with which to judge different options and partnership designs. By failing to apply this approach from the start, FMHP ran the risk of commissioning an evaluation without any sense of what success would look like. By definition, therefore, it could never be judged a success, because there were no criteria for making this assessment. For FMHP this also meant that no benchmarking data could be obtained early on in the partnership and therefore impact could not be demonstrated (which had led to some staff starting to lose faith in the partnership as it was seen not to have demonstrably delivered). Equally (and more cynically), it could never be judged a failure for exactly the same reasons.

Calling something a 'partnership' to make it sound better

One of the reasons behind the rapid rise in the use of the term 'partnership' outlined in the introduction to this paper is the fact that the term has such a 'feel-good factor' that it is hard to disagree with. A good example here is the concept of the Public-Private Partnership (PPP), which is arguably a market-based relationship (albeit often a long-term one) rather than a genuine partnership. However, by calling something a 'partnership' we reduce the likelihood of resistance and we automatically start to portray potential critics as unreasonable (for who could possibly be against the notion of partnership working?). As one of the current authors has previously remarked, adopting a policy of 'mortgaging off long-term public sector assets in return for short-term private sector cash that the government ought to be giving us anyway if it's serious about public service reform' is unlikely to be a vote-winner – calling it a 'Public-Private Partnership' somehow sounds and feels very different (personal communication). In the case of FMHP, a move which everyone agreed was a 'takeover' by Springfield was portrayed as a 'partnership' for the benefit of front-line staff. While this may have reduced initial dissatisfaction and resistance, it arguably came back to haunt senior managers when staff saw through the rhetoric almost immediately. Interestingly, this is an issue that seems less pronounced in the private sector, where there seems less embarrassment and greater clarity about acknowledging that any particular organisational integration can be a 'merger' or an 'acquisition.' Moreover, interviews senior staff members suggested that without the change in accountabilities which the transfer of staff brought, the 'partnership' would not have been sustained. As outlined below, the partners suffered a number of practical difficulties, and it was suggested that had these managerial changes not been

so difficult to reverse then FMHP may not have lasted and might have fallen at these early hurdles.

Not being honest about organisational drivers

While most people involved claimed that FMHP was set up to improve services for patients, the overwhelming sense from our initial evaluation was that it was primarily motivated by organisational interests. Again, this seems common in wider health and social care practice, where the user-focused justification for a particular policy change (often in a glossy consultation document) frequently seems at odds with the real motive of the organisation(s) concerned. In some cases, this seems motivated in part by embarrassment and by a sense that staff, service users and members of the public would not understand or agree with the real motives of the organisation. However, changing services because there is not enough money or in response to an adverse incident seems to us to be a potentially legitimate thing to do. What upsets staff, service users and the public in such situations, it seems to us, is not the fact that public services have to respond to such 'hard-headed' organisational realities, but that front-line services tend not to be honest about the real reason for their behaviour. In the case of FMHP, therefore, being honest about the desire to reduce duplication, simplify systems and (presumably) save money as a result seems an appropriate way forward, without the need to raise service user expectations by dressing the partnership up in user-focused (but probably unrealisable) outcomes. Again, this is something that often seems easier in the private sector, where companies can be honest about their

desire to increase market share and/or improve profits without the need to portray this in terms of immediate and direct consumer benefits.

Not being clear about unstated drivers

Closely linked to the previous issue is the tendency to establish partnerships for unstated rather than explicit reasons. In the case of FMHP, an adverse event, a serious case review, the threat of reorganisation and the need for a specialist mental health trust to position itself in a forthcoming reconfiguration all seem to have played a part in the formation of the partnership. By failing to acknowledge these motives, both Springfield and Shelbyville probably avoided some very difficult initial conversations with their staff and service users, but had to pay the price for this when the reality of the resulting 'partnership' was at odds with what staff initially envisaged from managers' early rhetoric. Unfortunately, this seems relatively common in the NHS at least, with research into a series of health care mergers suggesting that organisational changes badged in terms of service improvements were actually motivated in part by a series of unstated drivers (such as responding to management teams that were perceived to be 'failing' and responding to local and national politics) (Fulop *et al.* 2002, 2005). If the case of FMHP is anything to go by, similar processes seem to have been at work here too, with local partners feeling unable to be explicit about their underlying motives.

Being unrealistic and over-ambitious

When pushed to comment on desired outcomes, FMHP staff fell into the classic trap of seeing partnership working as a panacea and imbuing it with overly-ambitious aspirations (which is perhaps unsurprising given the wider institutional context – see discussion for further). Even without the organisational and unstated drivers discussed above, a new and relatively small organisational entity was arguably set up to fail because expectations were unrealistic. As a result, however it performs, the partnership is likely to be perceived as under-achieving and could therefore increase staff disillusionment with the concept of partnership working more generally. To make matters worse, many of the outcomes which individual staff were seeking bore no relation to the process of setting up a partnership, and there was no clarity over why a partnership of any kind should necessarily be seen as a good way of achieving such ends. Thus, some staff were eager to ensure that FMHP resulted in culturally sensitive services for a diverse local population. Laudable though this aim is, there is no reason why a partnership *per se* should be any better at this than a single organisation working autonomously - particularly when no additional systems or processes were put in place to achieve these aims. Indeed, such is the upheaval created by organisational changes such as this, that cultural diversity might actually have suffered in the short-term as managers and front-line staff focused more on setting up the new partnership. In many ways, this links to discussions above about being clear about outcomes and about being honest about motives – if cultural responsiveness was the genuine aim, then setting up a partnership was probably not the best way forward.

That this may be an issue beyond Springfield and Shelbyville is suggested by an innovative evaluation in Somerset (where Peck *et al.* 2002 studied the first integrated health and social care partnership trust in England). Despite being quoted as an example of national good practice in the government's ten-year plan for the future of health services (Department of Health 2000), the study found that two of the main priorities for service users – improving the quality of acute care and enhancing the respect shown by staff to service users – went unaddressed during the integration. From our analysis of FMHT, we would argue that this is hardly surprising – if tackling these two user priorities had been the main aim of the partners concerned, then Somerset would probably have chosen to go about this in a very different way (perhaps without the need for such a formal partnership at all).

Failing to attend to practical details

Finally, the way in which FMHP was established meant that senior managers announced the future direction of travel without paying sufficient attention to the practical details that needed to be in place to help the subsequent partnership run smoothly. Again, the literature on organisational mergers seems to suggest that this can be a common failing (see, for example, Author's own *et al.* 2006). Before the formal decision has been taken to merge, the literature suggests that the role of leaders and managers is essentially transformational in nature (Peck *et al.* 2006) – that is, it is about creating a vision for the future which those within the organisations buy into. However, once the decision to merge has been taken, the onus on managerial style will shift to being predominantly transactional in nature. In other words, leadership

should now be focused on the practicalities of making the vision outlined a reality. At this point it is imperative that staff are assisted through the change process to make this period as smooth as possible. As Devine and Hirsh (1998: 7) report, “employees are often hit by waves of anxiety and need to be supported through the transition” and they underline the importance of managers’ roles, behaviours and attitudes in influencing how well employees cope with this adjustment. Epstein (2004) goes as far as to suggest that a weak post-merger integration strategy can destroy an otherwise well-conceived merger. Yet, evidence from the private sector suggests that this aspect is often neglected in favour of commercial and financial considerations (Marks 1997; Carleton 1997). In the case of FMPH, although a vision had been articulated, senior managers assumed that the practical details which would underpin this vision would fall into place, but financial and procedural issues have continued to mar the relationship. Even two years on there seems little indication that these difficulties will be resolved. Moreover, one of the important mantras for leaders of organisational transitions such as this is communicate, communicate, communicate; upwards, downwards and outwards. A number of staff members both within FMPH and beyond suggested that if the partnership was particularly bad at one thing, it was communicating. As a result those working within FMPH were often unsure of what was happening, and wider partners were often unaware of even the existence of FMPH (with its relatively small remit), let alone its activities.

Discussion

As suggested above, we are not being overly critical of FMPH or, indeed, of those who work within it. What we are suggesting, though, is that the partnership

experienced a number of common pitfalls – many of which may be to some degree inevitable given the wider institutional context. As earlier outlined, the New Labour government has imbued the partnership concept with a large degree of importance and has presented it as the solution to a plethora of diverse problems. As some commentators (see McLaughlin 2004 for example) have suggested it is this very lack of definitional clarity over the term partnership that has helped the concept become so popular. By being relatively broad and encompassing, the answer to any number of potential difficulties could be suggested to be ‘partnership’- and arguably this has been the case over the last decade within English health and social care. Yet central government has been less clear about how ‘partnership’ should deliver the solution to all these difficulties, or indeed, what this solution actually looks like. Moreover, Author’s own (2008a) analyses health and social care policy since 1997 and suggests that it is unclear which theoretical drivers underpin ‘partnership’, highlighting the presence of a wide range of theories from a range of different disciplines (economics, political studies, institutional theory etc).

New institutional theorists (for example, DiMaggio & Powell, 1991a) suggest that a process of isomorphism may take place within institutions, whereby organisations adopt particular innovations not because they are proven to be effective, but because a number of key organisations have adopted these - or it has particular political salience. In other words, beyond a certain point, these innovations become, rightly or wrongly, associated with ‘success’ in terms of the institution and so are adopted on this basis. Given that ‘partnership’ has been an important tool within a range of public services over the past decade, this may help to explain why it is that FMPH (and other partnerships) have decided that this is a rational response within their given

contexts and have failed to identify desired outcomes. DiMaggio and Powell (1991a) identify three types of isomorphism:

4. Coercive isomorphism which comes from political influence and the problem of legitimacy;
5. mimetic isomorphism which comes from standard responses to uncertainty; and,
6. normative isomorphism which is associated with professionalisation.

We would argue that within the broad partnership field all three forms of isomorphism can be found. Clearly the government has produced coercive isomorphism by both explicit techniques (e.g. legal duty for health and social care agencies to work together under the Health Act 1999) and more subtle techniques (e.g. making partnership a necessary feature for some sources of funding). It is very clear to local organisations that the wider institutional context values partnership and imbues it with importance, so that it would seem natural to invoke this as an improvement mechanism, without necessarily being clear about why. In other words, not only does this term have political salience, but it is also seen as a standard response when facing a particular difficulty. This may help to explain why, when pushed, staff members often suggested very ambitious aims for the partnership – ones beyond which a change of organisational structures in itself could deliver. Moreover, calling the resulting entity a partnership (when arguably it is technically a takeover) will also make it more acceptable to staff members given that this concept is valued within this context. However, in the long term this is clearly quite a dangerous tactic – reaching the parameters of normative isomorphism. As we are starting to see, partnership is losing

some of its legitimacy within the wider health and social care community. Once this happens, even when 'true' partnership is the most appropriate response to a particular situation it may be dismissed out of hand due to the negative connotations it has acquired.

There is another important reason why these pitfalls are perhaps inevitable to a certain degree which is linked to that outlined above. Central and local agencies alike have pushed health and social care organisations locally to 'deliver' partnerships (although not necessarily being specific about why, beyond the fact that this is 'a good thing'). Central government have removed a number of the structural and legal difficulties involved in partnership working (e.g. legislation to create pooled funding arrangements, reorganising health care boundaries for increased co-terminosity with local authority social service departments, promising to streamline inspection regimes etc) and have suggested that it is now merely a matter of local agencies 'delivering' partnership. Indeed the New Labour government has continually espoused local agencies into 'delivery, delivery, delivery' and former Prime Minister, Tony Blair, suggested that a number of the reforms outlined during his term were thwarted by civil servants and managers failing to deliver. Yet, as Peck and Giddens (2006: xvi-xvii) argue the "concept of 'delivery' when applied to the local implementation of national policy, is a profoundly misleading one. 'Delivery'...suggests that the role of local public sector managers and professional is to simply adopt policy that is promulgated by government." In other words, implementing policy into practice is much more complex than central government has tended to suggest. Yet there are very real, but often neglected, issues over whether and how policy can be effectively implemented locally, and if so, what needs to be in place for this to happen. Although there is

much literature about how partners work together, in practice there is actually very little guidance for local leaders and managers to aid them in this process. Despite the fact that there is a wealth of experience of doing ‘partnership’ in practice within a health and social care context, beyond central government removing a range of structural and legal barriers, they have done little to aid local organisations in overcoming this ‘implementation gap’.

What all of this means in practice is that we have tended to see the same sorts of problems and issue cropping up time and time again within local health and social care communities that are attempting to establish partnerships. What local agencies need is not only clarity over what kinds of partnerships can deliver what sorts of outcomes, for which kinds of services user groups and when (Author’s own 2008a, 2008b); but also in doing so, which kinds of support mechanisms and processes need to be in place in order for this process to be successful. Without having access to this sort of information, health and social care partnerships will continue to repeat the kinds of patterns outlined above and it is likely that the partnership concept will lose any semblance of credibility within this arena.

Conclusion: rescuing the concept of ‘partnership working’

In our view, the case study of Springfield and Shelbyville’s Forensic Mental Health Partnership reveals a number of pitfalls with regards to the current emphasis on partnership working. In a worst case scenario, partnerships set up without clear desired outcomes, called a ‘partnership’ to appease potential critics and established for underlying motives that differ from the publicly stated aims of the partnership are

always likely to struggle, particularly if facing unrealistic aspirations and failing to pay sufficient attention to the practical operation of the partnership. When we argued in the title of this paper that partnership working ‘doesn’t work’, it is precisely these tendencies to which we were referring. This is not to suggest in any way that partnerships *cannot* work, more that the way they are operationalized, used and abused means that they are unlikely to be successful – either because there is no sense of what success would look like, because real success is very different to what we publicly proclaim we want to achieve and/or because we have been so over-ambitious that success was never really possible. Yet this is not necessarily to blame either FMPH or partnerships more widely, but is to some degree inevitable given the institutional context in which these ‘partnerships’ are being operationalized.

Against this background, the growing cynicism described in this paper seems entirely understandable – perhaps partnership is a concept that has attracted so much personal and organisational baggage that it has started to lose its appeal and potential impact. However, our aim in this paper is not to discredit the notion of partnership working, but actually to rescue the partnership concept (by stripping away unrealistic and cynical motives and aspirations). In our view, policy makers and front-line services who are clear about what they are trying to achieve via partnership working, are honest about their motives, are challenging but realistic in their aspirations and who design subsequent organisational relationships and structures with this in mind have the potential to achieve more together than they could alone. Sadly, the lessons identified in this case study suggest that current policy and practice is a long way away from this at present. To paraphrase and adapt a phrase from mental health

reformer and academic Peter Beresford (2007), “this isn’t rocket science. It’s much complex and important than that.”

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Appendix One: Academic papers derived from thesis

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Appendix Two: Screenshots from POET

Front page of the POET website

The screenshot shows the front page of the POET website in a Microsoft Internet Explorer browser window. The browser's address bar displays the URL <http://hsmcfs3.bham.ac.uk/questionnaire/>. The website's main heading is "POET: Partnership Outcomes Evaluation Toolkit" in a red serif font, positioned next to a photograph of a white building. Below the heading is a horizontal navigation menu with four items: "Home", "Guidance Materials", "Key Links", and "Contact Us".

On the left side of the page, there is a vertical list of links: "Why do we need to evaluate partnerships?", "Purpose of the toolkit", "How the toolkit was designed", and "Is POET for you?". Below these links is a section titled "Case Study Sites log-in" with a list of letters: "A", "Sandwell Integrated Support Service", "C", and "D".

The central content area features a large white box with a black border. It contains a welcome message: "Welcome to **POET**: The partnership outcomes evaluation toolkit". Below this, a paragraph explains that the toolkit was developed and funded by the Health Services Management Centre as part of a PhD studentship, and is designed as an evaluation resource for health and social care partnerships. It also mentions that the website houses resources for those involved in partnerships and hosts an online evaluation survey. A final paragraph encourages users to navigate the site, browse resources, and use the contact section for questions.

On the right side of the central box, there is a stylized logo for "POET" in red, with a small robot-like figure integrated into the letter "O".

The browser's taskbar at the bottom shows several open applications, including "Inbox - M...", "Referenc...", "Microsoft ...", "questionn...", "3 Micros...", "Home - ...", and "Microsoft ...". The system tray on the right shows the "Internet" icon and the time "12:45".

One of the help screens giving examples of answers

Home - Microsoft Internet Explorer

File Edit View Favorites Tools Help

Back Forward Stop Home Search Favorites Refresh Print Mail Messenger

Address http://hsmcfs3.bham.ac.uk/questionnaire/12.htm Go Links

msn Search Highlight Options Pop-ups Allowed Hotmail Messenger My MSN News

Home Guidance Materials Key Links Contact Us

Partnership service user outcomes

This section is designed to examine what it is the partnership is actually doing to make outcomes better for service users. To do this a 'theories of change' method is employed. This method examines the issue which is to be addressed, and what the long-term aims for this are. In order to move from the current context to the long-term aim there will be a number of issues that will need to be addressed and steps that will need to be taken. Below is an illustration of this process:

```

graph LR
    A[Issue to be addressed within present context (where we are now)] --> B[First step to get to where we want to be]
    B --> C[Medium term step to get to where we want to be]
    C --> D[Long term aim (where we want to be)]
  
```

It is unlikely that improving outcomes for users will involve one simple step; there may be multiple short term and medium term steps to be taken rather than just a simply linear process. Examples of such processes are provided below.

Issue to address	Short-term	Medium-term	Long-term outcome
<i>Little user choice</i>	<i>Increase support for direct payments</i>	<i>increase take-up of direct payments</i>	<i>increased choice</i>
	<i>Introduction of Practice-based commissioning</i>	<i>stimulation of providers</i>	

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Free text section of the survey

http://hsmcfs3.bham.ac.uk - Questionnaire - The School of Public Policy - Microsoft Internet Explorer

Questionnaire Sections	Personal Role - Positive Learning Points & Improvement Mechanisms 1																		
Personal Details X - Personal Details X Personal Role X - Your Role ✓ - Partnership Structure ✓ - Culture & Professional Identity ✓ - Communication & Learning ✓ - Positive learning points 1 X Organisational Issues X - Aims & Objectives ✓ - Leadership & Accountability ✓ - Ownership & Trust ✓ - Push & Pull Factors ✓ - Positive learning points 2 X User Outcomes X - Partnership service user outcomes X - Service user outcome X - Service user barriers X - Service process outcomes X - Positive learning points 3 X	6a Please indicate the three most positive aspects which you feel about your role and explain why. <table border="1"> <tr> <td>Learning Point 1</td> <td><input type="text"/></td> </tr> <tr> <td>Explanation 1</td> <td><input type="text"/></td> </tr> <tr> <td>Learning Point 2</td> <td><input type="text"/></td> </tr> <tr> <td>Explanation 2</td> <td><input type="text"/></td> </tr> <tr> <td>Learning Point 3</td> <td><input type="text"/></td> </tr> <tr> <td>Explanation 3</td> <td><input type="text"/></td> </tr> </table> 6b Please indicate at least three changes which would make your role easier on a day to day basis and explain why. <table border="1"> <tr> <td>Mechanism 1</td> <td><input type="text"/></td> </tr> <tr> <td>Explanation 1</td> <td><input type="text"/></td> </tr> <tr> <td>Mechanism 2</td> <td><input type="text"/></td> </tr> </table>	Learning Point 1	<input type="text"/>	Explanation 1	<input type="text"/>	Learning Point 2	<input type="text"/>	Explanation 2	<input type="text"/>	Learning Point 3	<input type="text"/>	Explanation 3	<input type="text"/>	Mechanism 1	<input type="text"/>	Explanation 1	<input type="text"/>	Mechanism 2	<input type="text"/>
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