

Partnership Working and the Implications for Governance: issues affecting public health partnerships

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Glossary of terms/abbreviations

CAA	Comprehensive Area Assessment
DPH	Director of Public Health
IDeA	Improvement and Development Agency
HAZ	Health Action Zone
HImP	Health Improvement Programme
HLC	Healthy Living Centre
JSNA	Joint Strategic Needs Assessment
LA	Local Authority
LAA	Local Area Agreement
LGID	Local Government Improvement and Development
LSP	Local Strategic Partnership
NHS	National Health Service
ODPM	Office of the Deputy Prime Minister
OECD	Organisation of Economic Cooperation and Development
PCT	Primary Care Trust
TPP	Total Place Pilot

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Executive Summary

Background

Much has been written about partnerships in the context of health and social care but far less is known about public health partnerships which are more complex and long-term in their impact on health outcomes. Partnerships are claimed to be 'a good thing' and have remained popular as an instrument of public policy in situations where issues cut across functions, organisations and professions. But partnerships incur significant transaction costs and may contribute less to improved outcomes than is claimed. The partnership literature is largely focused on process issues and the impact of partnerships on improving outcomes cannot be assumed. This study explored these concerns in a number of local case study sites in England.

Aims

The study aims were threefold:

- to clarify factors promoting effective partnership working for health improvement and tackling health inequalities (*context-focused*)
- to assess the extent to which partnership governance and incentive arrangements are commensurate with the complexities of the partnership problem (*process-focused*)
- to assess how far local partnerships contribute to better outcomes for individuals and populations using tracer interventions in selected topic areas to make such an assessment (*outcomes-focused*).

These aims resulted in a number of research questions, including: What is understood by public health partnerships? Can policy goals and objectives be achieved without partnerships? What are the determinants of a 'successful' or 'effective' partnership? What barriers exist to partnership working? What is the impact of partnerships on health outcomes? What issues do partnerships face in future?

Methods

For a conceptual framework, we drew on systems thinking and the notion of 'wicked issues', that is, problems that are not easily defined, are dynamic, have no clear solutions, are cross-cutting and multi-faceted. The study design comprised two stages: stage 1 was an exploratory review of the partnership literature to provide a context for the empirical stage and entailed a rapid systematic review. Stage 2 focused on 9 case study sites selected according to the strength of partnership working – high, medium, low – with 3 sites in each category. There were 3 phases to stage 2: (1) first round semi-structured interviews with 53 senior managers in the selected PCTs and lead elected members in the local authorities in each site; (2) follow up telephone interviews after 8 to 12 months with 8 out of the 9 DsPH in the study sites; and (3) 4 tracer issues identified from 4 of the study sites involving semi-structured interviews with 32 frontline practitioners and 4 focus groups with service users in 3 of the locations to establish how far partnerships impacted on their work and outcomes.

Results

The systematic review found that there is no clear evidence of the effects of public health partnerships on health outcomes. Despite enthusiasm for partnerships and a firm belief that they are essential, it is difficult to discern their precise impact on local policy or practice. Being able to establish with any degree of assuredness what outcomes have resulted from partnerships is almost impossible as is trying to track in what ways partnerships may have led to perceived outcomes or impact. Most of the success factors remain largely process-based.

The issues governing public health partnerships are not so different from those evident in other types of partnership, notably in health and social care. Given that these issues remain to the fore after over 10 years of partnership working in respect of public health (prior to this time, there was limited emphasis on such partnerships), it might be expected that there would be more evidence of impact and added value.

The 9 local case studies selected according to varying degrees of partnership working (high, medium, low) appear to fit these categories but it remains impossible to determine how far they have impacted on health outcomes for better or worse. More likely, partnerships are but one component in a complex mix of factors that go towards shaping whatever outcomes emerge in an area.

Structures like Local Strategic Partnerships (LSPs) and Local Area Agreements (LAAs) may have less impact on the success of partnerships than relational factors and the prevalence of trust and goodwill. Where these exist, the potential for information sharing and avoiding service duplication is far more likely to occur.

Being able to establish any link between partnerships and outcomes is rendered more difficult by a disconnect between what happens at a strategic level (ie the LSP/LAA level) and what happens subsequently on the ground locally among frontline staff. Frontline staff adopt a different approach to partnership working from those above them. It is marked by pragmatism, flexibility and an organic quality that gets lost at higher levels where the approach adopted is much more formal and governed by which structures are required to be put in place and which targets are to be met.

Viewing partnerships locally in isolation from the overall national public policy context in which they operate is a mistake. Constant policy and organisational changes, together with weak joined-up government at national level, have a direct impact on the ability of local agencies to work together.

Two key related features of health policy since around 2000 have been the encouragement of competition and choice in public services coupled with a growing diversity among those providing services, including public health, in order to stimulate the market. Both developments have made partnership more challenging and complex. There is a tension between a desire to be collaborative on the one hand and the pressure to be competitive on the other whereby members of partnerships may be working for a range of different organisations each with its own priorities, values and cultures. The absence of system alignment can adversely affect partnership working.

While the Comprehensive Area Assessment and the OnePlace initiative, including Total Place, (introduced by the last Labour government and replaced with place-based budgeting by the Coalition government) have stressed the importance of place and whole communities, individual agencies still function for the most part as separate organisations with their own governance arrangements and targets. These tend to take priority over LAAs and the work of LSPs although the various targets do get bundled together to form the LAA. However, this has its own drawbacks since it militates against finding new innovative solutions that are not dependent on individual agencies and their priorities.

User views of partnerships are indirect and may be derived from their experience of services. Their experiences vary but there seems to be no direct link between the quality of a partnership and the services received.

Conclusions

B Our research shows that many of the issues facing public health partnerships remain remarkably similar to those that have beset other types of partnership. Partnerships continue to be rather messy constructs with no clear causal relationship between what they do and what the partner organisations achieve by way of outcomes. Arising from our study of 9 local areas a number of implications for partnerships and recommendations for research have been identified.

Future implications for partnerships

1. Formal partnerships can be effective in process terms and the success factors are those that have already been documented in the literature. But when it comes to outcomes it may be that more flexible, looser framework structures that can be adapted quickly in the light of review, evaluation and learning are preferable. There is possibly much to learn from the way frontline practitioners organise themselves jointly to make things happen. In addition, making collaboration an integral part of performance management systems for both individuals and departments would give added impetus to partnerships.
2. Effective partnerships appear to have more to do with relational factors than structural or systemic ones. Introducing collaborative or integrative leadership development to nurture and develop skills for joined-up working seems essential since such leadership requires the adoption of a different mindset in which the effective functioning of a team or partnership as a whole is the purpose.
3. There may be lessons for how partnerships need to be formed and function in the context of complex systems and tackling wicked issues. Arguably, governance requirements in respect of LSPs and LAAs may be disabling given the type of partnerships needed to meet particular public health challenges.
4. What happens (or not) at local level is affected in various ways by developments at national level so a lack of joined up working at that level has consequences for efforts locally to join up; this suggests a need for greater, and more coherent, systems alignment both vertically between levels of government and horizontally across agencies at each level.
5. Giving permission to public sector professionals and managers to experiment and try out new and different ways of solving problems has merit (precedents exist in the experience of Health Action Zones and Healthy Living Centres where constant adaptation was a feature); evidence for such an approach seems to fit well with the Total Place initiative or whatever may replace it. Such initiatives

could help overcome many of the current barriers to effective partnership working with their focus not on organisational silos but on place and whole communities. For example, appointing elected members/non executive directors who sit outside traditional departmental and organisational structures (national or local), oversee pooled budgets, and have a focus on outcomes might be considered.

6. Continuous political and organisational churn is not conducive to effective partnership working. It is a fact of life in public services but still carries a high cost in terms of disrupted relationships and lost corporate memory and experience that can facilitate partnerships and which are not easily recreated. It may be unrealistic to expect things to change but the point merits making all the same – minimising as far as possible constant policy and organisational turbulence and churn which risks hampering effective cross-sector working and the development of sustainable relationships based on trust and understanding. The coalition government's proposals for significant change in the NHS and the public health function pose risks in this respect.

Recommendations for future research

1. Partnership working is destined to become more complex and challenging in future in the light of a greater emphasis on competition and diversity of provision as set out in the government's plans for reforming the NHS and public health. Research will be needed to understand these new partnership forms, which are likely to include social enterprises and private sector partners, and to assess their effectiveness.
2. Experiments with different forms of partnership which rely less on formal structures and more on what appears necessary to tackle complex public health challenges should be encouraged and evaluated.
3. Research is needed to follow up collaborative leadership development initiatives to assess their impact on practice.
4. With changes likely in the location and tasks of Directors of Public Health and their teams together with the establishment of a National Public Health Service as a result of the government's NHS reform proposals, it is essential that the evolution and impact of the changes are appropriately evaluated.

The Report

1 Policy Context and Background to Research

Partnership working has become a *sine qua non* of British public policy, especially since the late 1990s. Its appeal lies in the fact that few challenges facing government at both national and local levels fall neatly within the confines of a single department or organisation. This is particularly true of the majority of challenges facing public health which are cross-cutting in nature and involve several policy arenas, organisations and professional groups.¹ Partnership working is neither a new nor recent phenomenon but it has become more pervasive in recent years. At the same time, failures in public policy are invariably laid at the door of ineffective or malfunctioning partnerships. Paradoxically, the more important partnership working has become as a mechanism for ameliorating or solving complex problems, the less effective it appears to be. The difficulties which persist have been evident for many years but have not dampened successive governments' enthusiasm for partnerships and for regarding them as essential to the successful prosecution of a raft of policies.

This study of public health partnerships in England is concerned with understanding the appeal of such partnerships at a sub-national level where they have been subjected to little analysis. Although many of the issues affecting partnerships are likely to be common across all types, public health partnerships pose particular challenges that merit further inquiry. A focus of the study is on outcomes and the extent to which it is possible to ascribe any progress with improvements in health and wellbeing to partnership working. The study aims to shed light on this issue in two ways: first, by examining the connection, if any, between the work of partnerships to devise strategies and priorities on the one hand and the activities of those working on the frontline to deliver services and interventions to meet those strategies and priorities as primarily articulated in LAAs on the other; and, second, by obtaining the views of service users who may have views about the extent to which their experiences have in any way been influenced, or shaped, by the efforts of partnerships.

Establishing a causal link between partnerships and outcomes is by no means a straightforward question to research. In part, this is because of the very complexity of both the problems being addressed and also the partnerships themselves which have the potential to become 'the indefinable in pursuit of the unachievable'.² Moreover, for some commentators achieving better health outcomes may not be the sole or even primary purpose of partnerships. Douglas,³ for instance, suggests that

while partnership working is not an end in itself, 'it is a process and a mindset, *one outcome of which may be a better service*' (emphasis added).

1.1 Some key issues surrounding partnerships

As noted, the appeal of, and appetite for, partnerships has grown in recent years. The arrival of the New Labour government in 1997 ushered in an era of renewed interest, and almost an abiding faith, in partnerships and joined up government more generally.^{4,5} Together they have been key components of a 'wave of interest in "horizontal" approaches to governing and organising'.⁶ Reflecting this increased interest, Glasby and Dickinson⁷ note that the word 'partnership' was recorded 11,319 times in 2006 in official parliamentary records, compared to a mere 38 times in 1989. The prevailing orthodoxy has been that partnerships are intrinsically 'a good thing' and a 'must have' if only because many complex problems demand a cross-cutting approach if they are to be successfully tackled. Despite there being a sizeable literature on partnerships, their typologies, and on how to do them better, there are a number of important deficits which inspired the research reported here.

First, most of the research on partnerships has focused on the links between health and social care (see, among others, the published work of Hudson, Glendinning, Glasby, Dickinson). With few notable exceptions (eg the evaluation of major initiatives such as New Deal for Communities, Health Action Zones and Healthy Living Centres) there has been little research examining those partnerships concerned with public health. Although they confront many of the same issues as those arising in all types of partnership, including those arising from networked governance and the often fraught relationship between strategic objectives and frontline working, it seems a fair assumption to make that public health partnerships are more complex and long term in their impact on health outcomes. For the most part, this is because they are concerned with 'wicked issues', that is, issues where complex interdependencies are involved, where causality is difficult to unravel or ascribe, and where outcomes are unpredictable or may have unintended consequences.^{8,9,10} Such complex problems also go beyond the capacity of any one organisation to understand and respond to, and there is often disagreement about the causes of the problems.

Compared with public health partnerships confronting such 'wicked issues', those in health and social care are comparatively straightforward. They may be complicated but not complex, with the goals they seek to achieve being reasonably clear and well-defined. In contrast, public health goals are invariably less clear and often contested. For example, should the focus on tackling obesity be on children or adults or both? Should it be on tackling individual behaviour or on collective action such as taking the food and drink industry to task for manufacturing, and/or selling cheaply, unhealthy products high in sugar, salt and fat that contribute to obesity?

In addition, there is the sheer breadth of the public health function with its focus on the so-called three domains of health promotion, health protection

and health service improvement, and the multiple ways in which public health issues are conceptualised, operationalised and prioritised across various sectors.¹¹ In respect of 'wicked issues', these arise in regard to the first of the domains – health promotion – whereas the other domains deal largely with what might be termed critical (eg swine flu), rather than complex, problems (eg obesity). It is the first of the domains that is the focus of our research on public health partnerships. From whatever angle they are viewed, such partnerships embrace a more extensive range of diverse agencies, departments, professional groups and end users and are invariably tasked with complex, multi-level and intersectoral interventions for which the evidence may be partial and/or contested or even absent altogether. And as noted, the very causes of the problem are likely to be multiple and subject to differing interpretations.

A second deficit arises in the context of the available literature on partnerships demonstrating a significant, and almost exclusive, focus on process issues rather than on outcomes. This is not to denigrate the importance of process in understanding both how partnerships work and can succeed, and in identifying those components of a successful partnership that might usefully inform other partnerships being established. But the danger in focusing only, or largely, on process lies in an implicit assumption that it is a given that partnerships are desirable and will result in better outcomes just by *being*. Conversely, rather less attention has been given to the significant transaction costs that partnerships incur – many are 'high maintenance'¹² – and to the possibility that they may contribute less to better outcomes than is assumed, or claimed, and that there might be alternative and less costly means of achieving the same, or better, results. Echoing Dowling and colleagues¹³ call, the need is for research which seeks to explore the success of partnerships in effecting changes in service delivery and, if possible, to establish the subsequent effects on the health and wellbeing of a population. Notwithstanding the difficulties besetting such a project, the research reported here is, in part, a response to that call while making no claims to be the last word on such matters.

Finally, very few studies have explored the issue of why joint work should be seen as a 'good thing' and therefore why it should be done in the first place.¹⁴ There is an abiding faith that it is a critical element of public service delivery.

1.2 Limits to partnerships

The term 'partnership' is problematic for another reason, namely, its looseness and absence of precision. It is a slippery, and something of a portmanteau term, which can be employed to mean a multitude of things. That constitutes both its appeal and its weakness. One of the dilemmas arising from such laxity of language is that often the precise nature of the problem or deficiencies to which partnerships are seen as the solution is not at all clear or self-evident. The term 'partnership' covers (and at the same time often conceals) 'a multi-dimensional continuum of widely differing

concepts and practices, and is used to describe a variety of types of relationship in a myriad of circumstances and locations'.¹⁵ Partnership working may be seen as one, if not the only, cure to a number of deficiencies whose root causes may go deeper and lie elsewhere.^{16,17}

Calls for partnerships are often based on a number of untested and unproven assumptions, including that frontier problems are by their nature organisational in origin; that the necessary skills are present; that there are clear goals to which partnerships are directed; and that every partner agency already functions optimally within its own boundaries with no allowance made for possible intra-agency malfunctioning. Yet, as Rein¹⁸ has argued, the search for better joint working can camouflage 'the multiple, conflicting hopes that parents, politicians, administrators and professional service providers and interest groups impose'. Many problems evident in service planning and delivery may therefore not in fact be problems of an absence of, or defective, partnerships even if they are presented as such. Overlaying partnerships on them is unlikely to be a successful strategy and could have the unintended consequence of bringing partnerships into disrepute.

If partnerships are not the solution to every organisational and professional problem, then what other factors might be responsible? Ambiguous legislation, policy incoherence and misalignment, organisational inertia, confused aims, professional tribalism, poor leadership and management can all influence the extent to which partnerships are achievable and succeed. Rather than adopting a generic, 'one size fits all' approach to partnership working, a customised bespoke approach might fare better. Context is not unimportant, as Powell and Dowling¹⁹ are all too aware. They conclude: 'there is a significant literature suggesting that different organisation types, governance arrangements, and working processes are applicable to the accomplishment of different tasks, objectives and strategies... . There is no reason to presume that partnerships are generic and will be immune to the need to find the appropriate structure and processes for the achievement of particular kinds of tasks and goals'.

1.3 Study aims and objectives

It is against the policy context and background briefly described above that the research reported here was undertaken. The study set out to address the following three key aims:

- to clarify factors promoting effective partnership working for health improvement and tackling health inequalities (*context-focused*)
- to assess the extent to which partnership governance and incentive arrangements are commensurate with the complexities of the partnership problem (*process-focused*)

- to assess how far local partnerships contribute to better outcomes for individuals and populations using tracer interventions in selected topic areas to make such an assessment (*outcomes-focused*)

To meet these three aims, the study set itself eight objectives:

- to systematically review evidence on partnership working with a view to drawing out and applying the lessons for partnerships in health improvement, including tackling health inequalities
- to draw out the implications for public health partnerships of systematic reviews of the effectiveness of interventions, particularly those around the social determinants of health and health inequalities
- to provide an assessment of incentives for partnership working in the context of Local Strategic Partnerships, Local Area Agreements, Joint Strategic Needs Assessments, and the creation of joint Director of Public Health posts
- to examine the operation of joint Directors of Public Health posts and other such posts
- to identify the range of partnerships related to health improvement in selected case study areas and assess their effectiveness in relation to selected topics of public health importance
- to identify and describe the leadership behaviours which promote effective partnership working and correlate with high achievement in developing health improvement and a narrowing of health inequalities
- to assess the implications of the various partnership arrangements for public health governance
- to consider the impact of partnerships and joint posts on end users.

To a greater or lesser degree, the study was able to address each of these aims and objectives. The research itself is an example of a partnership between the researchers at Durham University and members of the Local Government Association's Local Government Improvement and Development's (LGID) – formerly known as the Improvement and Development Agency (IDeA) – Healthy Communities Programme. One of the LGID's principal initiatives has been the development and application of a peer review benchmark aimed at identifying local government's contribution to promoting healthy communities on a range of parameters, including partnership working and the skills required for it. The close collaboration with the LGID has been useful at all stages of the study but especially in the selection of sites for the case study fieldwork, testing emerging findings from the research, and feeding back emerging findings to the healthy communities network.

Using intelligence from the LGID's peer review benchmark, together with other sources known, and intelligence available, to the research team, a sample of nine locations (comprising PCTs and their corresponding local

authorities) each producing a Local Area Agreement (LAA) were selected to study more closely over a period of some 18 months. The nine locations were grouped into three categories with three sites in each and these were labelled: strongly-partnership based, moderately partnership-based, and weakly partnership-based respectively. In addition, four tracer issues were identified in four of the nine locations in order to assess how far partnerships impacted on frontline staff and, where possible, on end users and their experience of services. The topics identified were those to which the four sites selected attached high priority in their respective LAAs. They were also identified as among the key challenges facing those areas in the Department of Health's Health Profiles and in the Comprehensive Area Assessment findings. Finally, to explore the nature of joint DsPH posts, interviews were conducted with our sample of DsPH. Unfortunately, in the end we were unable to expand on the number of interviews in this part of the study as we had hoped owing principally to the unexpected move of a key member of the research staff but also because we needed additional time to complete data gathering on the four topics having decided to undertake additional interviews to capture the range of views we encountered. Although we have been able to make some observations on the workings of joint posts, we consider them to be a topic that merits more detailed study. However, it is also likely that such posts will be overtaken by events. Under the coalition government's proposals for NHS reform, Directors of Public Health will transfer to, and be employed by, local authorities.

1.4 Conclusions

In conclusion, the study reported in subsequent chapters is intended to advance both thinking about, and understanding of, partnerships in the specific context of public health (by which we mean health improvement and wellbeing rather than health protection or health service improvement) and to be able to say something about where they add value, and where perhaps they do not, in an area (ie public health) where studies of partnership working have been notable for their absence. Since we lack clear evidence about when, where and which types of partnerships, if any, might be appropriate, or on whether complex policy problems such as those affecting public health might be better dealt with through alternative conceptual frameworks and approaches which may not involve partnerships as we know them, research which addresses these issues is both desirable and timely.

2 Partnership Working and Public Health

In this chapter, we explore the notion of 'partnerships' and their public health context a little further – what they mean, what types exist, and why they persist in holding strong appeal even when their impact is unknown or contested. Key factors contributing to the success of partnerships or, conversely, those factors creating barriers or limitations are also reviewed. The literature on partnerships is considerable and covers every conceivable angle – motivation for working in partnerships, how partnerships get formed, the qualities and competences required by those working in partnership, typologies of partnerships, toolkits to assess and improve partnership working (eg that produced by the Nuffield Institute for Health, based at Leeds University²⁰). The aim here is not to provide a comprehensive or exhaustive review of the literature but to select some key features in order to provide a backdrop to the empirical study which follows and which concentrates on public health partnerships in the shape of LSPs and the LAAs for which they are responsible.

During the first term of the Labour government between 1997 and 2001 significant energy and resources were expended on innovative forms of partnership, notably Health Action Zones and Healthy Living Centres. During the government's second term of office (2001-05) the appeal of such initiatives wore thin. In part this was a consequence of a perceived lack of impact of such initiatives combined with an impatience for quick results. Ministerial changes also resulted in a shift of emphasis and priorities although throughout these, partnership working remained central to the government's response to public health priorities. The drive centred on LSPs and LAAs which are described further in subsection 2.1.1 below. Further discussion of the background to the study and the process issues which have been the focus of most of the published work on partnerships can be found in the paper by Perkins and colleagues.²¹

2.1 Define your terms

As noted in Chapter 1, 'partnership remains a varied and ambiguous concept'.²² The guiding rule in public policy seems to be that the more complex the problem the more likely it is to need a partnership. Definitions of partnership abound and range from two words – 'working together' – to whole books on the subject. One definition of partnerships by the OECD²³ is appropriate in the context of our study of partnerships:

Systems of formalised co-operation, grounded in legally binding arrangements or informal understandings, co-operative working relationships, and mutually adopted plans among a number of institutions. They involve agreements on policy and programme objectives and the sharing of responsibility, resources, risks and benefits over a specified period of time.

Pollitt²⁴ suggests, as we have also noted above, that partnerships became especially popular around the mid-1990s as part of a new 'soft-focus image of government' that emerged in response to a perception of government being too hard and tough. The watchwords of this new mood were 'networking', 'partnering', 'joining-up', 'involving', 'engaging' and 'relational', and all described a new approach to governance and the process of governing. All these terms have colonised political and managerial discourse and analysis since this time and remain in good currency although accompanied by a growing critique of the mismatch between their intent and the reality of dysfunctional systems and structures. Indeed, our research reported in later chapters arises from an attempt to understand and account for this paradox.

Pollitt²⁵ gets to the nub of the issue when he offers his impressions of the literature which can be contrasted with what he calls the 'rosy-hued views purveyed in some official statements'. As he states, while some partnerships work well, others do not with difficulties commonplace. However, while the impression given in successive policy white papers and other statements is that partnerships 'are a well-understood, all-purpose piece of managerial technology', the chief message to be drawn from the academic literature is rather different. In this, partnership is viewed as a variable concept that is often not well-understood and often fails to perform effectively. This leads Pollitt²⁶ to conclude: 'there are many situations in which [partnership] should probably not be the government's first choice of organisational form'.

In public health, and drawing on the published literature, the motives for partnership can be identified as being largely the consequence of recognition that no single agency can possibly embrace all the elements that go to contribute to a policy problem or its solution. Take obesity, for example. As the Foresight report showed, tackling what they call 'an obesogenic environment' demands a complex systems response that entails joined-up action across a range of agencies at all levels, both vertically and horizontally.²⁷ The call for a total government response predates the current interest in Total Place or its successor, place-based budgeting (see below).

What the literature also shows, despite a misconceived assumption that partnerships of equals are the norm comprising individuals who come together out of a desire to share knowledge, skills and resources, is that a state of happy contentment is the exception rather than the rule.^{28,29} More commonly, there are marked power disparities between members with some individuals being able to veto proposals of which they disapprove. There is therefore nothing flat or horizontal about partnerships although a rather general use of the term can give the impression that there is. In this respect use of the term is misleading and belies a whole set of issues. The only certainty is that there is no single partnership form but rather multiple forms.

2.2 Types of partnership

The sheer variety of partnerships can be bewildering and nowhere more so than in public health. We have not sought to define public health partnerships too tightly preferring instead to take our cue from our respondents in terms of the partnerships with which they had most contact. Moreover, such partnerships vary greatly across the country in terms of types and titles and we are obliged to respect our respondents' anonymity. In any case, our interest has been in understanding partnerships from the perspective of their impact (or not) and the factors contributing to this. To this end, their titles and types are less important.

For our purposes it is helpful to note that partnerships generally fall into one of the following categories: public-public or public-private (with private meaning either for-profit commercial companies or not-for-profit third sector voluntary bodies, or a mix of the two). There are also different tasks for which partnerships are deemed necessary with the consequence that three ideal-typical forms of partnership working have been identified by Snape and Stewart:³⁰ *facilitating partnerships*, which manage longstanding strategic policy issues; *coordinating partnerships*, which are concerned with the management and implementation of policy based on broadly agreed priorities; and *implementing partnerships*, which are pragmatic and concerned with specific, mutually beneficial projects.

These definitions of partnerships, and what they do, nicely capture the types of public health partnership that are the chief subject of study here. These include Local Strategic Partnerships (LSPs) operating through the production of LAAs. LSPs and LAAs are examples of facilitating partnerships by allowing for a more coherent approach to local commissioning across a range of funding streams and different partnership and governance arrangements. Both have been in operation for some time and LAAs have been required throughout England since April 2007. LSPs take the form of partnerships between public, private and third sector organisations with the aim of creating a framework within which local partners can work together more effectively to secure the economic, environmental and social wellbeing of their area.³¹ The purpose of LAAs is to strike a balance between the priorities of central government and local government and their partners in reaching a consensus on how area-based funding will be used. The underlying concept behind LAAs is outcome based and involves local government choosing up to 35 targets from a longer list of central government priorities (ie the National Indicator Set). Local partners are then (in theory) left to decide how best to achieve these targets.^{32,33} Under the LAAs all partners are statutorily accountable for targets agreed across a local authority area and assessed through the Audit Commission's Comprehensive Area Assessment (CAA) (which occurred in 2009 only as the CAA was subsequently abandoned by the Coalition government elected in May 2010).³⁴ LAAs comprise up to around 50 targets which are agreed collectively through negotiations between local areas and Government Offices. To achieve outcomes, LAA frameworks explicitly seek to promote

coordination and partnership working between government departments and agencies through a statutory 'duty to cooperate'.³⁵

2.3 The value and impact of partnerships

One of the most difficult issues in partnerships is getting to grips with precisely what they are intended to achieve and whether they in fact succeed in their endeavours or whether not having them would make any difference to the outcome. As Pollitt³⁶ concludes: 'academic research does not indicate that the partnership form (or, more accurately, forms...) regularly produce(s) performance gains. In other words, we cannot assume that they usually 'work', in terms of delivering better programmes'. It is a conclusion borne out by the work of Huxham and Vangen,³⁷ two of the most experienced researchers working in the field of partnerships. Their findings focus on attending meetings where the achievements are few and, where they do occur, are 'slow and painful'. They conclude: 'It is not uncommon for people to argue that positive outputs have happened despite the partnership rather than because of it'. Other researchers have pointed out that precisely because the problems partnerships have been set up to address are complex and enduring, it is not a straightforward matter attributing any improvements found to them or to what they do by way of interventions.³⁸ For such reasons, Boydell and colleagues³⁹ consider that partnerships should be valued from the perspective of 'intangible assets'. This led to the development of a model describing the benefits of partnerships in terms of how they improve health.⁴⁰ These benefits included:

- the connections made by partnership members
- the learning that takes place
- the enhanced capacity to act as a result.

Confronted with the charge that these are essentially process measures, Boydell and colleagues defend their model on the grounds that connections or relationships made through partnerships are achievements and may be regarded as 'benefits'. Such intangible assets, they suggest, add value and may be viewed as investments which will bear fruit in future. They believe this to be a more useful approach than measuring outcomes which relate to past performance rather than seeking to help improve future performance. Moreover, the concept of intangible assets focuses on the relational aspects of partnerships which are likely to be an essential ingredient of any success.

Given the great variety of partnerships, and the varied contexts within which they operate, it is rather meaningless to discuss them in general terms or draw conclusions about their value and impact. It is therefore necessary to know much more about their composition, their goals, their resources and the rules governing their operation as well as something about the particular context in which they are operating.

Two recent, and well documented, examples of public health partnerships are Health Action Zones (HAZs) and Healthy Living Centres (HLCs) both of which were products of New Labour's early enthusiasm in the late 1990s for mould-breaking cross-cutting initiatives. HAZs were announced in mid 1997 soon after Labour entered office and by April 1999 there were 26 in total. They were intended to act as 'pioneers' and 'trailblazers', finding and promoting new ways of working together across services including education, employment, housing and health.⁴¹ Most HAZs survived for between three and four years during which time they engaged in a wide range of activities, sponsoring hundreds of workstreams and thousands of projects. HAZs also embraced a complex myriad of partnerships which meant there was no single or standard model. Precisely because of this diversity and complexity, which was difficult to capture, it was not possible to establish with any confidence or certainty what impact they had on outcomes as measured by indicators of population health or health inequality. At best, according to the national evaluation, HAZs 'built local capacity and demonstrated change possibilities. They did this in innovative and sustainable ways that will continue to be useful for many years to come'.⁴² Because of the variety of models and partnership structures, the result was 'a mosaic that does not lend itself to easy or brief summary or to unambiguous judgements about success or failure'.

This conclusion gives rise to a more general lesson concerning policy research which is also applicable to the study reported here. Users of policy research tend on the whole to expect clear answers about impact and subscribe to a rational, linear model of the link between an intervention and an outcome. But, as we have tried to demonstrate, and explore further below, complex systems dealing with 'wicked issues' are not susceptible to such an approach to change. A more realistic outcome from evaluations of such systems, as the HAZ national evaluation concluded, is that they 'contribute to a process of enlightenment about highly complex processes that are interpreted by different actors in multiple ways'.⁴³ It is a conclusion reached some 20 years earlier by Smith and Cantley⁴⁴ in their evaluation of a psychogeriatric day hospital where they adopted a pluralistic evaluation approach to capture the different conceptions of success employed by staff to evaluate the hospital's impact.

The HLC programme was set up in 1998 to fund community level interventions to address health inequalities and improve health and wellbeing in innovative ways. The evaluation of the overall programme acknowledged that 'gathering evidence of impact from complex community interventions...is a challenge'.⁴⁵ The programme funded 351 HLCs which generated a diverse range of activities tailored to the needs of their local communities. In keeping with a key theme to emerge from the evaluation, namely, the importance of working flexibly, adapting activities and approaches to changing circumstances within their local communities, none conformed to a single standard type or model. As a consequence of this approach, the evaluation concluded that HLCs were successful in engaging some of the most deprived sections of their local community. There was also evidence of improved coordination and cooperation between existing

services although HLCs varied considerably in respect of their organisational structures with some being quite simple, while others were complex. In respect of encouraging and bringing about a more 'joined up' approach, while most HLCs set up some kind of formal partnership with various local agencies, many opted for less formal links as well as taking part in other local partnership arrangements. The twin tasks of managing a partnership and maintaining successful links were regarded as 'a challenging and resource intensive side of their work'.⁴⁶ Very few HLCs (17.2% of respondents) said there were no drawbacks of partnership working. A key feature of HLCs' success was their proximity to their communities and their understanding of their complex needs. It enabled them to shape services and influence providers. Important, too, was the finding that the local partnerships represented by HLCs sometimes struggled to fit into larger scale partnerships such as LSPs in England and their equivalent elsewhere in the UK. While some were successful in building relationships with these partnerships, others experienced considerable difficulties or were rebuffed in their attempts to establish links. As the evaluation report notes, these findings raise issues about whether such locally based partnerships may be more effective at achieving closer coordination than higher-level partnerships that all too frequently get distracted by repeated restructuring and reorganisation. If this is the case, then such small local-level partnerships might merit more support to sustain them. Certainly some of the problems many HLCs experienced are echoed by findings from our study, especially the issue of connectivity between strategic partnerships and joined up working at a more local level.

Within the specific context of LSPs and LAAs, in which we are primarily interested as the focus of our study, there is little published material on their operation and impact presumably because of their recent origins, especially in the case of LAAs which only came into effect in April 2008 although a few existed as early as 2005. LSPs were established in 2001 and have been regarded as having had the main responsibility for community wellbeing. A study from the Institute for Government finds a widespread welcome for LAAs as a demonstration that partnerships are being taken seriously.⁴⁷ The study suggests there has been much progress although much of it related to developing new relationships. These, it is claimed, have been useful in demonstrating the interconnectedness of a wide range of problems. The study, however, also documented a number of challenges. One of these was the finding that processes remain too resource-intensive with the LAA process remaining rather bureaucratic. Coordinating the LAA process in the areas visited involved at least two people working close to full-time.

Despite the resource intensive nature of the initiative, it was claimed that 'this activity was not translating into action at the rate that many had hoped'.⁴⁸ Changes in spend in respect of the area based grant had not occurred and there were no examples of significant increases in pooled budgets for cross-agency purposes. The process of selecting LAA priorities did not always align with other local strategies and timelines with the result that LAA priorities would not impact on budgets until April 2009, some 10

months after having been agreed. Another important finding was that while local government has been given responsibility for partnership working, which many involved in public health would agree is a welcome development, it has insufficient authority over local partners, including NHS organisations, to drive the agenda. As Gash and colleagues⁴⁹ point out, this is primarily because these bodies are required to respond to their own national lines of accountability and separate national performance management frameworks and policy priorities emanating from the Department of Health. Countervailing pressures, largely in the form of financial incentives to progress LAA priorities, are weak and/or modest in nature (eg around £40,000 per area for each target met over a three year period). Compounding the problem is that local government often lacks the control over funding that is required to drive innovative cross-agency approaches. In this context, considerable emphasis is being placed on the comprehensive area assessments which were published in late 2009. But it is not clear whether these will exert pressure on *all* local agencies rather than on local authorities alone.

The Institute for Government study also found that what happened, or did not happen, locally in regard to cross-agency working was shaped by the degree to which cross-departmental working occurred nationally. Since it remained weak, it was hardly surprising that local agencies struggle to join up or align policies handed down vertical silos. We return to the issue of system alignment in section 2.4 below.

2.4 Partnerships: success factors

Much of the available literature on partnerships and interagency collaboration tends to focus on matters of structure, strategy and process and offers criteria by which to judge a successful partnership.^{50,51} However, as our systematic review of the impact of organisational partnerships on public health outcomes found, there is an absence of clear evidence of the effects of public health partnerships on health outcomes.^{52,53} In one study in progress examining partnerships for health improvement in Glasgow, achieving outcomes is being understood in terms of improved access to services, equity of distribution, improved efficiency and effectiveness (as measured by service and quality standards and a reduction in service duplication), improved experiences for staff, users and carers as well as improved health and wellbeing.⁵⁴ Some of these factors (eg improved access to services, improved efficiency) might look like process measures to some observers. It may be that a distinction needs to be made between intermediate and final outcomes. With the exception of the last item mentioned by Fischbacher and colleagues the others may more accurately appear to be examples of intermediate outcomes. A focus on outcomes is not to downplay the importance of process and other issues identified in the work of Hudson, Dowling and others since much of the evidence shows that successful partnerships are more about attitudes and culture. However, the dilemma remains that while a partnership may be successful in its own terms, making the link between this and its contribution to an outcome that

may or may not have been shaped by its existence and activities is hard to establish. Our study, reported in later chapters, has wrestled with these issues but makes no claim to having resolved them.

In any discussion of partnerships, it is also desirable to be specific about the type of partnership being discussed, the context in which it is to operate, and what the success criteria are supposed to be assuming they have been set out and agreed in the first place. For example, it may matter whether a partnership has emerged organically from some identification of a local issue that merits attention from a mix of skills and agencies rather than one that has been formed because it is required, or imposed, by some higher authority. If a tick box exercise, the partnership may be seen locally as a rather artificial construct that may not enjoy legitimacy or be effective. In these circumstances, merely listing the attributes or characteristics of a successful partnership is a rather meaningless exercise especially if the obstacles in their path are such that the chances of success are negligible.

Among the conditions for success that the literature suggests are the following:

- key decisions need to be made at the outset of a partnership and set out in a plan that has the agreement of all partners
- lines of responsibility need to be clarified and agreed
- achievable goals need to be identified and stated
- incentives should be introduced in the pursuit of the stated goals to encourage their achievement
- systematic and regular monitoring is required to ensure that the partnership is on track
- effective and committed collaborative leadership at a senior level is essential
- trust is an important ingredient among those taking part in partnerships.

Of course how these various factors get played out in actual practice, their respective weighting, and the balance between them, will vary according to the particular partnership in question, its purpose and the context in which it is located. Beyond a certain level, generalising about the ingredients of a successful partnership may not be especially helpful. Moreover, having clearly specified goals may not in fact be possible in an area of considerable uncertainty, like public health, where specifying the goal in advance may either not be possible or could possibly be misleading and perhaps result in unintended consequences. Rather, the goal may be *emergent* and become evident only once those engaged in finding solutions to the problem start to tackle it. However, rather than accept, or even embrace, the unavoidable messiness of public health issues, the instinctive reaction is usually to reduce complexity and try and achieve greater certainty in order to move into the simple system zone.⁵⁵ So, if a partnership is seen not to be working, the temptation is to resort to a reductionist or essentially mechanistic approach by proposing that the partnership be made statutory, or by strengthening monitoring arrangements to ensure that the partnership delivers what it promises.

Such tinkering with existing arrangements and constructs may provide temporary or minimal relief but more likely they will disappoint. In contrast to rational, linear and reductionist thinking, systems thinking suggests that it is better to try multiple approaches and let the desired direction arise by focusing on those things that seem to be working best, ie adopting an emergent approach. In Seddon's⁵⁶ words, it means thinking 'about the organisation from the outside-in' in order 'to integrate decision-making with work' – it is to understand the nature of the task or problem to be tackled and to design a systems that meets it. So, according to this way of viewing the world, new possibilities are explored through experimentation and through working at the edge of what is known. Getting heads round the problem is certainly desirable but perhaps not through pre-existing and often over-engineered partnerships that themselves may militate against finding new ways of tackling complex problems. A systems perspective challenges the accepted ways of managing and governing affairs, viewing them as part of the problem rather than the solution. Systems failure occurs when the capacity of a system to adapt is no longer possible. The consequence is a growing sense of distance, disillusion and frustration in those designing policy and those implementing it. We explore this particular relationship (and tension) in our study (see chapter 6). A possible reason, then, for partnership under-performance or failure is the misplaced attention focused on structures and systems which, perhaps unintentionally, have resulted in limiting the adaptive potential of partnerships which is essential in tackling 'wicked issues'.⁵⁷

The notion of 'backward mapping' is helpful in understanding this relationship between those designing and implementing policy respectively.⁵⁸ For Elmore, the critical issues are where, in the complex welter of relationships at the delivery level, are the individuals who have the closest proximity to the problems, and what resources, financial and otherwise, do they have to address them? In this sense, the goal of backward-mapping is to isolate the one or two critical points in a complex multi-partner relationship of the type under study in our research that have the closest proximity to the problem, and identify what needs to happen at those points to solve the problem or meet the objective.

Systems thinking does not offer a panacea or a 'silver bullet' solution or magically make complex problems disappear.⁵⁹ But it demonstrates that managing complex adaptive systems demands a new mind set that may be more focused on improving what can be done rather than trying to meet a specified target or goal that may be unrealistic, unattainable or just wrong. Adopting a systems perspective, the process of designing, formulating and implementing policies is based more on facilitation of improvements than on control of the organisation or system. As Chapman⁶⁰ puts it: 'the aim should be to provide a minimum specification that creates an environment in which innovative, complex behaviours can emerge'. Moreover, the leadership style within a systems approach will be based more on listening, asking questions and co-producing possible solutions and less on telling and instructing. Partnerships could operate in such a manner thereby providing an appropriate mechanism for applying a system approach. But from the

available evidence it does not seem that many, if any, partnerships in practice function in such a way. Like the host organisations which spawned them, and to which they report, they seem to be more comfortable operating in a reductionist mode rather than a systems mode. Part of the reason for this is the highly prescriptive context in which they have been set up and are managed – a notable feature of the public service reforms implemented in the period from around 2000.⁶¹ Adopting a systems perspective requires being non-prescriptive about means so that only a minimum specification is deemed necessary. This would then allow an opportunity to test out different partnership approaches and styles, rejecting those which were not successful while retaining those that seemed to work (see section 2.6 below).

As noted earlier, partnerships are slippery. They may generally be deemed 'a good thing' in rhetorical terms but whether they are in practice is dependent on many factors that will be specific to the particular problem or issue that a partnership is set up to tackle. Conceivably, adopting a systems perspective may help overcome some of the problems and limitations associated with partnerships, and identified in the literature, so that they can become more effective. Building and managing partnerships is essential to a systems perspective but different skills are needed to enable them to work effectively from those commonly found.⁶¹ The type of skills needed for systems thinking compared with more traditional, reductionist approaches are illustrated in Table 1.

Table 1. Skills of systems thinking

Usual approach	Systems thinking approach
<p><i>Static thinking</i> Focusing on particular events</p>	<p><i>Dynamic thinking</i> Framing a problem in terms of a pattern of behaviour over time</p>
<p>Systems-as-effect thinking Viewing behaviour generated by a system as driven by external forces</p>	<p>Systems-as-cause thinking Placing responsibility for a behaviour on internal actors who manage the policies and 'plumbing' of the system</p>
<p>Tree-by-tree thinking Believing that really knowing something means focusing on the details</p>	<p>Forest thinking Believing that to know something requires understanding the context of relationships</p>
<p>Factors thinking Listing factors that influence or correlate with some result</p>	<p>Operational thinking Concentrating on causality and understanding how a behaviour is generated</p>
<p>Straight-line thinking Viewing causality as running in one direction, ignoring (either deliberately or not) the interdependence and interaction between and among the causes</p>	<p>Loop thinking Viewing causality as an ongoing process, not a one-time event, with effect feeding back to influence the causes and the causes affecting each other</p>

Source: de Savigny and Adam⁶³

2.5 Partnerships: potential problems and limitations

Commonly identified problems with, and limitations of, partnerships are often the converse of the success factors described above, namely, poor or weak leadership, an absence of resources and incentives to facilitate effective partnerships, no clear or consistent goals, a lack of trust and so on. There can also be problems over accountability where no single partner feels fully accountable for the actions of the partnership. Invariably,

responsibility is split across the partners which can give rise to the question 'who is in charge'? The transaction costs involved in taking part in and servicing partnerships also need to be identified and accounted for since they can be significant. Unless they can be offset against clear benefits associated with partnerships, then it may be that their value can (and should) be challenged. Added to these potential problems are many others arising from organisational difficulties, including differences in missions and values, professional orientations, structures, and political settings (eg the NHS and local government respectively). At a strategic level, and this is highly pertinent to the study reported here, effective partnership working may be undermined by the rigidity of institutional and policy structures. Such vertical 'silos' are a feature of the way government departments and agencies operate and are organised but the effect on LSPs can be considerable and contributes to their ineffectiveness. This is especially evident in respect of public health challenges none of which fits neatly within the remit of any single government department or agency.^{64,65}

A report from the Institute for Government briefly considers joining up outside Whitehall by devolving power to local actors which is the logic behind LSPs and the LAA framework.⁶⁶ It is also a key driver behind the Total Place initiative which seeks to support innovation and efficiency by a focus on place rather than on separate organisational silos.⁶⁷ But the report concludes that 'the efficacy of many of these mechanisms is likely to be seriously limited so long as departmentalism at the centre remains a problem'.⁶⁸ It is a conclusion supported by a report from the New Local Government Network which studied the 13 Total Place Pilots (TPPs).⁶⁹ The study argued that major change was needed at the centre to break the existing top-down models and cultures of accountability and service delivery. The challenge for local areas was already considerable but was being made more difficult and undermined by current systems of funding and accountability. The clear message seems to be that more effective local coordination does not remove the need for joining up within Whitehall. Indeed, in its absence, local initiatives are likely to fail or malfunction.

Different philosophies among partners can also result in malfunctioning or under-performing partnerships. While some of these may be aggravated by the issue of central-local relations just noted, they may also reflect different cultures at local level between, for example, the NHS and local government. In particular, as McQuaid⁷⁰ notes, an integrated 'policy culture' that is shared by agencies and groups involved in delivery is important if partnerships are to be effective. He notes that where policy culture becomes fragmented, partnership working can quickly disintegrate. Securing such an integrated policy culture may be problematic within a particular organisation, such as the NHS with its multiple constituencies, let alone between organisations. For example, the absence of policy, and therefore system, alignment is a critical one in public health where many of the NHS's policies seem to conflict with the objective of strengthening health and reducing the demand on health care services, especially acute hospitals. This is before local government even gets a look in. And within the local government sector there may be a lack of alignment within local

authorities between a focus on the economic regeneration of local areas on the one hand and the efforts to improve health and wellbeing on the other. The strong message from the literature is that partnerships are destined to fail if set up in a policy culture that is fragmented, misaligned and dysfunctional.

2.6 Alternatives to partnerships

Given the notion of complex adaptive systems which we have used to frame the study, an issue which we explore at some length in our research is whether the model of partnerships that has arisen in public health around LAAs and LSPs and variants, notably, health and wellbeing partnerships, is the only or optimal model or whether there are other approaches that might achieve more at less cost. The question takes on a particular piquancy and greater urgency in the bleak financial climate public services are entering. There is little hard evidence on what alternatives might be available and be effective although the concept of complex adaptive systems offers some useful pointers. There is also an interesting passage in the study of Whitehall noted earlier of the three key challenges facing it, namely, strategy, governance and collaboration respectively. On the last of these, the Institute of Government's report states in an important passage:⁷¹

We try to avoid assuming that collaboration implies neat and tidy organisational structures and processes, or that it depends upon formal coordination machinery. Indeed, our research clearly shows that the real value of effective joining-up mechanisms lies in their ability to foster new kinds of conversations and relationships between key players in government. *These relationships cannot be over-engineered – effective problem-solving may sometimes come, at least in theory, from competition, conflict and even a little chaos at the margin.*

Although this comment is aimed at central government departments, it may be equally applicable to efforts at partnership working locally. Conceivably, there has been an over-engineering of partnerships at this level through LSPs and joint posts without sufficient attention being given to whether these mechanisms are, or can be made, effective or whether there might be more to be gained from a focus on the relational aspects of working collaboratively (see, for example, Elson⁷²).

A similar argument is articulated by a former adviser to Tony Blair when he was prime minister during his first term of office. Leadbeater⁷³ maintains that the problem lies in public organisations having been designed as bureaucracies to process large numbers of cases in identical ways. Such organisations 'are divided into professionally dominated departments with activity concentrated into narrow specialisms, with little cross-fertilisation of ideas or practices'. He goes on to argue that generally public organisations 'have heavy-handed management systems which provide limited autonomy or personal responsibility for front-line staff'.

The issue of trust, or its absence, seems to lie at the heart of the problem. Overall, strong trust is equated with long-term relationships which have

become virtually impossible in public services which seem to undergo continuous change with their staff experiencing constant churn. Leadbeater argues that perhaps the belief that trust can only be present where long-term relationships have been nurtured and allowed to survive is overstated. He believes that some of the most creative and productive relationships are often based on intense, short-term trust. 'This is the kind of trust that the film, advertising and entertainment industries thrive upon. When a crew comes together to make a film, for example, they may not know one another, but will work hand in glove for a few weeks very intensively'.⁷⁴ Conversely, he suggests that long-term trusting relationships can become cosy and collusive and result in problems of their own that, paradoxically, make long-term, mutual trust the enemy of creative and innovative joint working. It is an issue to which we will return.

As we have suggested, complex adaptive systems thinking can point to different ways of approaching partnerships which may be helpful in their functioning in an area like public health. Indeed, thinking about public health as a system helps demonstrate the complexity and interrelated nature of the issues involved.⁷⁵

2.7 Conclusions

As this chapter has sought to highlight, partnerships are notable for their considerable complexity and diversity which, in turn, impact on their development and effectiveness. The literature does indicate a set of critical success factors as well as barriers to success. But improving partnership working is hampered by an absence of understanding in the research to date in regard to why we have partnerships at all, what form they should take, what they contribute to outcomes, and what alternatives there might be to the heavily engineered partnerships of the type that generally prevail in public services and which are the focus of our research. In exploring these issues in subsequent chapters, a number of issues recur and we will return to them in our final chapter. However, it is worth mentioning them here to alert the reader.

In adopting a critical perspective on public health partnerships, which is the focus of our research, there is a need to identify the optimal balance between an organisation (such as a PCT or a local authority) carrying out its activities alone, with the potential benefits of reduced transaction costs, clearer accountability and possibly speedier action to deal with the problem, and one carrying out its duties in a partnership like an LSP or similar with all the associated costs and benefits outlined above. There may be a mid-way position between these extremes whereby the partnership element of tackling a problem may be more limited and confined to specific cross-cutting issues. Or, as suggested above, there may be ways of achieving effective collaboration but through less of a focus on structures and organisational systems and more of an emphasis on relationships, skills in collaborative working, including appropriate leadership, and on ensuring that policy is shared or aligned in such a way as to enable collaboration to occur.

As the evidence shows, merely overlaying partnership structures on an already fragmented system in which policy is neither aligned nor shared is almost a guarantee of failure. The finger of blame is then pointed towards the partnership for failing to deliver rather than tackling the root causes of the problem. Following a description of the study design and research methods in Chapter 3, the remainder of this report is concerned with these and related issues, exploring them through a study of public health partnerships conducted in nine English localities chosen to reflect a range of positions in regard to how effective their partnerships were deemed to be at the time of the research.

3 Study Design and Methods

In pursuit of the study aims and objectives, a variety of methods were adopted. The study comprised two main stages. Stage 1 took the form of an exploration of the partnership literature to test the perception that most of the research on partnerships focused on process rather than outcome. A systematic review of the literature on partnerships and its purpose was undertaken to provide a context and background for the empirical work in stage 2. The results of the systematic review are reported in sub-section 3.1 below (see also Smith and colleagues,⁷⁶ and Perkins and colleagues⁷⁷). Stage 2 focused on the nine case study sites that were selected (see section 3.2 below) and proceeded in three phases (see section 3.3 below). The purpose of stage 2 was to focus on the health policy activities of LSPs and LAAs, which are the principal means by which public health objectives are progressed at local level between PCTs and local authorities.

Finally, in addition to strengthened partnerships, another component of the government's determination to reinvigorate and embed joint working in public health across different agencies was the move to establish joint posts in respect of PCTs and LAs, in particular among Directors of Public Health (DsPH). There had for some time been examples of such joint posts in parts of the country but they were largely ad hoc and far from being the norm. This was no longer to be the case. Therefore, although not part of the main study design, a further stage of the study envisaged augmenting the interviews with the nine Directors of Public Health in our selected sites with some additional interviews with a sample of jointly appointed DsPH. This component of the study was not included as part of the costed SDO proposal and was intended as an add-on to the main study, reflecting the particular interests of a member of the original team. In the end, we had to abandon this stage as the person who planned to undertake the interviews subsequently vacated her post and there was insufficient resource to undertake the additional interviews. However, we have still been able to draw upon the interviews with eight of the nine DsPH and others interviewed in stage 2. In any event, as noted in the last chapter, proposed changes in the organisation and delivery of public health will, if enacted, mean that Directors of Public Health will become the employees of local government. Joint DsPH as we have known them will cease to exist.

3.1 Exploratory phase

As noted earlier, research testifying to the importance of partnership working in health and the processes involved is prominent in the literature. However, it is far from clear to what extent (if at all) partnerships contribute to achieving better population health outcomes despite the claim often made that they do and that this therefore constitutes a major benefit of joint working. For example, in a recent report for the LGID (formerly the IDeA) on effective joint working to tackle health inequalities one of the significant benefits stated by interviewees was better health outcomes emanating from a whole systems approach.⁷⁸ However, no examples were

offered of how partnerships had directly resulted in improved outcomes in health. Despite such assertions, which appear unsupported by evidence, a systematic review was conducted in order to establish the extent of the evidence base concerned with this issue.

Systematic review of the impact of partnerships on public health outcomes

The review set out to identify both quantitative (longitudinal before and after designs) and qualitative empirical studies (including 'views' studies) that examined the impact of organisational partnerships on public health outcomes in England by which we meant a focus on health improvement and/or a reduction in health inequalities. The review also outlined 'process issues' that affected the effectiveness of partnership working. These were: engagement of senior management in partnerships, lack of financial and human resources, sharing information and best practice, contextual challenges, importance of coterminosity of local authority and PCT boundaries, and in policy terms the need for 'quick wins'. Outcomes issues focused on the outcomes achieved by working in partnership and the effectiveness of monitoring and evaluation in regard to assessing the impact of partnership working. The inclusion and exclusion criteria are presented in Figure 1.

Figure 1. Inclusion and exclusion criteria

Public health partnerships were defined as: organisational partnerships (of two or more organisational bodies) which aim to improve public health outcomes (through population health improvement and/or a reduction in health inequalities). To be included, studies had explicitly to describe the public health partnership under evaluation, or assess one of the key known public health partnerships (such as LSPs, HAZs, Neighbourhood Renewal Partnerships, or HImPs). In terms of outcomes, included studies had to contain data on the impact of public health partnerships on health outcomes either directly (for example effects of partnerships, or partnership implemented interventions, on self-reported health) or indirectly (by, for example, raising the policy profile of health inequalities). Studies that only involved partnerships based outside of England and those of partnerships which were terminated by (or during) 1997 were excluded. Similarly, partnerships designed to improve clinical health outcomes, the control of infectious diseases or outcomes relating to the treatment of illnesses were not included. Opinion or theoretical based papers that did not draw on empirical data were excluded, as were studies that only examined processes of working in partnership (as opposed to public health outcomes) and non-English language papers.

Eighteen electronic databases were searched from January 1997 to June 2008. These covered academic research, local and central government studies and grey literature. Full details of the electronic databases and

websites, and the key words and terms used to drive searches are provided in Appendix 1. In addition, the bibliographies of all included studies were hand searched and information on unpublished or in-progress research was requested via author contact. In total, 1058 abstracts/titles were located, of which 895 were excluded at the titles and abstract stage; 163 papers were retrieved for full paper analysis with full data extraction conducted on 31 studies. Data were extracted and studies were critically appraised and independently checked. Any disagreements were resolved by joint re-examination. Critical appraisal criteria for qualitative papers were adapted from Rees and colleagues⁷⁹ and the Public Health Resource Unit,⁸⁰ while quantitative studies were appraised using criteria applied in previous systematic reviews of complex public health interventions and the existing guidance for the evaluation of non-randomised studies (see Figure 2).^{81,82,83,84} The critical appraisal criteria were applied with respect to the general design of studies, once it had been decided to include them (as opposed to being applied to the ability of studies to address the systematic review question), and the results were used for descriptive purposes only to highlight variations in the quality of studies. No quality score was calculated.

Figure 2. Critical appraisal criteria

These criteria were used to appraise all of the included studies.

Qualitative studies

- 1) Is there a clear statement of the research question and aims?
- 2) Was the methodology appropriate for addressing the stated aims of the study?
- 3) Was the recruitment strategy appropriate and was an adequate sample obtained to support the claims being made?
- 4) Were the data collected in a way that addressed the research issue?
- 5) Are the methods of data analysis appropriate to the subject matter?

- 6) Is the description of the findings provided in enough detail and depth to allow interpretation of the meanings and context of what is being studied? [Are data presented to support interpretations, etc?]
- 7) Are the conclusions/theoretical developments justified by the results?
- 8) Have the limitations of the study and their impact on the findings been considered?
- 9) Is the study reflexive? [Do authors consider the relationship between research and participants adequately and are ethical issues considered?]
- 10) Do researchers discuss whether or how the findings can be transferred to other contexts or consider other ways in which the research may be used?

Quantitative studies

- 1) Is the study prospective?
- 2) Is there a representative sample?
- 3) Is there an appropriate control group?
- 4) Is the baseline response greater than 60%?
- 5) Is the follow-up greater than 80% in a cohort study or greater than 60% in a cross-sectional study?
- 6) Have the authors adjusted for non-response and dropout?
- 7) Are the authors' conclusions substantiated by the data presented?
- 8) Is there adjustment for confounders?
- 9) Were the entire intervention group exposed to the intervention? Was there any contamination between the intervention and control groups?

- 10) Were appropriate statistical tests used?

Of the 31 papers where data were extracted, only 15 studies included any health outcomes and specifically assessing the impact of partnership working on public health outcomes was not the main focus of most of these (limitations of this review are considered below). The other 16 studies only looked at process issues.⁸⁵ This supports previous claims that there is a dearth of research adequately exploring the impacts of partnership working and that persistent policy support for the concept is largely faith-based.^{86,87} For summary details of the reviewed studies, see Smith and colleagues,⁸⁸ Tables 1-3.

The systematic review of outcomes had limitations as, indeed, any review of complex and difficult-to-define interventions is likely to have. Particular problems arose over the term 'partnership' and a lack of clarity over its meaning and the diverse nature of public health. It was not therefore possible to employ broad search terms because the number of references returned became unmanageable. Conceivably, therefore, our search strategies may have missed relevant studies although steps were taken to minimise this possibility through piloting and revising the search strategies and employing an experienced librarian to conduct them.

Overall, our review found little evidence in the available literature of the direct health effects of public health partnerships thereby vindicating the need for further research as proposed in stage 2 of the study reported here. Where successes relating to the public health outcomes were observed, it was extremely difficult to assess the extent to which these were directly attributable to partnership working for the following reasons. First, 'partnership working' was rarely adequately defined and many of the studies assumed that evidence of supportive attitudes to working in partnership were themselves a positive outcome and a proxy for success. Second, the studies largely involved multi-faceted interventions that did not rely solely upon partnership working and that often overlapped with other similar interventions, making it difficult to attribute outcomes directly to partnership working. Third, many of the studies reported that the public health aims of the interventions shifted during the lifetime of the intervention, with the consequence that initial methodological approaches were overtaken within the study period (a common problem with evaluating health policy as noted by Pope and colleagues⁸⁹). The problem was exacerbated by the short time-spans and relatively small-scale nature of most of the interventions.

In addition, the systematic review found that the quality of the majority of studies was limited (see Figure 3). Most were relatively small-scale, qualitative evaluations which focused on capturing the perceptions of managers and other actors involved in implementing the partnership-based interventions. To be able to determine whether or not an intervention is having an effect on the health of the target population, either a quantitative study design is required or a more sophisticated approach needs to be taken to the qualitative evaluation, with more attention given to gathering data from individuals whose health the intervention is intended to improve. Our study has sought to go some way towards meeting this challenge.

Although some of the qualitative studies reviewed suggested that health inequalities moved up local policy agendas, they could not attribute causality, particularly as the health inequalities were simultaneously being given more prominence in national policy discourse. Further, there was very little evidence as to whether the health improvement interventions initiated by partnerships would have been implemented regardless of the partnerships or whether the interventions were able to continue after the partnerships ended.

Figure 3. Quality of the evidence

Many of the qualitative studies lacked clear and well focused objectives and the methodologies were often poorly reported, with sparse data on numbers of participants, a non-comprehensive sampling strategy and a lack of information on the process of gathering and analysing data. In addition, few original data were included to support the authors' interpretations. Consequently, in a number of instances it was difficult to assess whether the conclusions were fully justified. Perhaps most significantly, though, the vast majority of the studies examined the views of those involved in partnership working (e.g. public health managers or commissioners, who may have had an interest in providing a positive assessment of the intervention), rather than those potentially affected by them (i.e. the local population).

Similarly, the quantitative studies reviewed were subject to a number of limitations relating to methodological approach. Given the type of interventions under review and the intended effects on public health outcomes, the follow-up period was relatively short (2 years in all cases). In one instance the findings were compromised by the use of an inappropriate control as well as a low follow-up rate. Possible contamination between intervention and control groups was a cause for concern in two other studies. Finally, there were no studies of the cost-effectiveness of partnerships, which is a notable lacuna given the high costs of partnership working (e.g. HAZs cost £320 million).

The principal conclusion from the systematic review is that while partnerships hold considerable, and seemingly endless, appeal to policy-makers, it is not possible from the available published literature to offer definitive evidence as to their impact on health outcomes. The findings from the systematic review reaffirm what other researchers and reviewers have found.^{90,91} Assessing the impact of partnerships on health outcomes is challenging from various perspectives, including methodologically. Establishing whether partnerships work from either a qualitative or quantitative point of view is far from easy to achieve. As has been pointed

out, studies of complex interventions frequently report having been constrained by short-term policy time frames and constantly shifting demands from central government.^{92,93,94} These facts of political life seem unlikely to change.

The fact that evidence on the effectiveness of partnerships is lacking does not necessarily mean that they are ineffective but, without such evidence, it needs to be acknowledged that the benefits attributed to this way of working are largely presumed. This observation takes on greater salience in the present public spending context when the far from insignificant costs associated with partnerships (both financial and human) are taken into account. The need for research on the issue of the added value partnerships bring is therefore widely accepted and the present study is an example of this recognition. It takes the form of a comparative analysis of interventions and strategies with similar public health aims which have adopted partnership working as their *modus operandi* and/or *vivendi*. A sample of nine LSPs was selected and they have been studied from the perspective of both those engaged in the partnerships and those who might be expected to benefit from their efforts, including frontline staff delivering improved health and its recipients. The remaining sections in this chapter examine the methods involved in selecting the sample and conducting the fieldwork.

3.2 Site selection

The research was conducted in nine local authority and corresponding PCT areas in England. The field study sites were chosen in consultation with members of the LGID (formerly the IDeA) Healthy Communities Team and the selection was informed by its healthy communities' peer review benchmark⁹⁵ in which local authorities are assessed as to how well they are tackling health improvement and health inequalities in their locality. Assessing the effectiveness of partnerships in combating health inequalities is a key element of the peer review process. As a co-investigator on the study, the LGID's input into selecting the nine field sites was critical and we drew heavily on their deep knowledge and experience which also had the advantage of being up-to-date in a rapidly changing policy and organisational environment.

The LGID benchmark for healthy communities is comprised of four themes:⁹⁶ (1) leadership, (2) empowering communities, (3) making it happen, and (4) improving performance. Each of these is further divided into three key elements. The issue of partnership is an important component of themes 1 (all three elements – vision, strategy, leadership), 3 (the elements concerned with resources and delivery), and 4 (all three elements – performance management, learning culture, support). Our field sites in the high partnership-based category were performing at the highest level; those in the moderate category were performing well; and those in the weak/low category were not performing as well as they might. Admittedly, these categories are somewhat subjective in the judgements being made by the peer review team but the tool was validated and well-

received by those subjected to it so should be deemed a fair assessment of performance. It certainly seemed sufficiently robust to employ it in identifying the sample of field sites.

The sample comprised nine sites which were grouped into three categories with three local authorities and matching PCTs in each category. The nine sites were ranked high performing (sites 3, 6 and 8), moderate performing (sites 2, 5 and 9), and low performing (1, 4 and 7) in regard to partnership working. Our research findings in these sites concur with the LGID's ranking of their performance in regard to partnership working. For example, in site 1 – a low performing authority – the LGID noted in their healthy communities peer review that:

- leadership needed to be strengthened, simplified and communicated
- a rationalisation of the partnerships and related bodies was required
- relationships at the highest level needed to be built
- frontline and middle managers would benefit from top-level leadership being more visible and providing more support.

Our research findings in site 1 show that leadership was hampered due to poor working relationships between the PCT and local authority. In addition, it was commonly observed that partnership structures were too complex. Furthermore, frontline practitioners voiced concerns over the lack of support and coordination from those in leadership roles.

A further check on the robustness of the selected sites, and their grouping into three clusters displaying varying degrees of effective partnership working, was undertaken when the CAA rankings were published in December 2009 under the Oneplace initiative. This brings together the views of six independent inspectorates, including the Audit Commission and Care Quality Commission. It is not possible to make direct comparisons between the rankings of our locations according to the LGID's peer review benchmark and those from the CAA since the factors included in the assessments differ. The issue of partnerships is not singled out for attention in the CAA's organisational assessment. However, the overall rankings in each case broadly supported the threefold categorisation of partnership working adopted for the research, with no area being a significant outlier or seemingly out of kilter with what would be expected.

3.3 Conducting the fieldwork

The field work in stage 2 of the study was conducted in three phases:

- *Phase 1:* first round face-to-face interviews with senior managers in the selected PCTs and lead elected members in relevant local authorities in each selected site.
- *Phase 2:* follow up telephone interviews with eight out of nine Directors of Public Health in the selected sites.

- *Phase 3:* 4 tracer issues identified in 4 of the selected sites for closer study both vertically and horizontally to establish how far frontline practitioners, middle level managers and, where possible, users of services consider how far (if at all) existing partnership arrangements have contributed to improved outcomes as experienced by them; data were collected through a mix of face-to-face interviews with staff and focus groups with service users.

In phase 1, 53 interviews were conducted with a range of actors, including: Directors of Public Health, Directors of Performance, Health Scrutiny Committee Leads, Chairs of Local Strategic Partnerships, Directors of Commissioning, and Directors of Health Improvement to elicit their views on the effectiveness of partnership working in improving health outcomes. Table 2 provides a breakdown of the recruitment for this phase.

Table 2. Recruitment for phase 1 interviews

PCT = Primary Care Trust Employee LA = Local Authority Employee

<p>Site 1</p> <p>Director of Public Health (PCT)</p> <p>Director of Commissioning (PCT)</p> <p>Scrutiny Committee Chair (LA)</p> <p>Cabinet Member - Portfolio Holder for Adult Services and Health (LA)</p>	<p>Site 2</p> <p>Director of Public Health (Joint Post LA/PCT)</p> <p>Senior Public Health Strategist (PCT)</p> <p>Director of Finance and Strategy (PCT)</p> <p>Health Partnership Manager (LA)</p> <p>Health Scrutiny Chair (Councillor)</p> <p>Director of Community and Housing (LA)</p> <p>Acting Scrutiny Manager (LA)</p>
<p>Site 3</p> <p>Director of Public Health (Joint Post LA/PCT)</p> <p>Director, Health & Wellbeing (PCT)</p> <p>Service Director Modernisation and Performance (LA)</p> <p>Health Scrutiny Chair (Councillor)</p> <p>Director of Commissioning (PCT)</p>	<p>Site 4</p> <p>Director of Public Health (Joint Post LA/PCT)</p> <p>Assistant Director of Commissioning (PCT)</p> <p>Deputy Director of Policy and Performance (LA)</p> <p>Clinical Governance Facilitator (PCT)</p> <p>Clinical Governance Facilitator (PCT)</p> <p>Scrutiny Committee Health Lead (Councillor)</p> <p>Chair of Local Strategic Partnership (Independent Chair)</p>

<p>Site 5</p> <p>Interim Director of Public Health (PCT)</p> <p>Consultant in Public Health (PCT)</p> <p>Director of commissioning (PCT)</p> <p>Director of Performance (LA)</p> <p>Scrutiny Health Lead (Councillor)</p> <p>Chair of Local Strategic Partnership (Councillor)</p>	<p>Site 6</p> <p>Director of Public Health (Joint Post LA/PCT)</p> <p>Local Strategic Partnership Member (Councillor)</p> <p>Head of Culture, Health and Wellbeing (LA)</p> <p>Deputy Director of Commissioning (PCT)</p> <p>Partnerships and Performance (LA)</p>
<p>Site 7</p> <p>Director of Public Health (Joint Post LA/PCT)</p> <p>Strategic Director of Health and Adult Community Care (LA)</p> <p>Strategic Director Children and Young People Services (LA)</p> <p>Programme Director - Health Partnership (PCT)</p> <p>Principal Health Policy Officer (PCT)</p> <p>Chair - Health Scrutiny Commission (Councillor)</p> <p>Executive Member for Culture and Healthy Communities (Councillor)</p> <p>Director of Commissioning (PCT)</p>	<p>Site 8</p> <p>Director of Public Health (Joint Post LA/PCT)</p> <p>Director of Policy and Resources (LA)</p> <p>Scrutiny Committee Health Lead (Councillor)</p> <p>Commissioning Manger (PCT)</p> <p>Deputy Director of Public Health (PCT)</p> <p>Director of Citizen Engagement & Communications (PCT)</p>
<p>Site 9</p> <p>Director of Public Health (Joint Post LA/PCT)</p> <p>Scrutiny Committee Health Lead (Councillor)</p> <p>Director of Commissioning (PCT)</p> <p>Chair of Local Strategic Partnership (Councillor)</p> <p>Deputy Chief Executive (LA)</p>	

In phase 2, 8 follow-up interviews were conducted with DsPH. In one of our sites (site 5) the DPH had left and their successor was too new in post to be interviewed.

In phase 3, 32 interviews (8 per site) in four study site areas (sites 1-4) were conducted with practitioners from the statutory, private and voluntary sectors. Each site represented a tracer issue theme (i.e. site 3, smoking cessation). Table 3 below gives a breakdown of the practitioners interviewed with a mix of frontline staff and middle managers although many of the latter also performed frontline work.

Table 3. Recruitment for phase 3 interviews

FP = Frontline Practitioner MM = Middle Management or equivalent role

<p>Site 1 – Alcohol Cessation</p> <p>Consultant in Public Health Medicine (MM)</p> <p>Executive Director (Alcohol Charity) (MM)</p> <p>Director of Strategy & Commissioning (Alcohol Partnership) (MM)</p> <p>Clinical Lead for the Alcohol Partnership (MM)</p> <p>Area Manager (National Probation Service) (MM)</p> <p>Clinical Nurse Specialist and Brief Advice (FP)</p> <p>Nurse Consultant, Dual Diagnosis Clinical (FP)</p> <p>Director - Substance Misuse Services (MM)</p>	<p>Site 2 – Obesity</p> <p>Joint Consultant in Public Health (MM)</p> <p>Joint Consultant in Public Health (MM)</p> <p>Health Improvement Coordinator (FP)</p> <p>Leisure and Culture Development Manager (MM)</p> <p>Registered Public Health Nutritionist (FP)</p> <p>Leisure Centre Sports Manager (FP)</p> <p>Diet and Fitness Manager (FP)</p> <p>Environmental Charity Manager (MM)</p>
<p>Site 3 – Smoking Cessation</p> <p>Service Manager – Smoking Cessation (MM)</p> <p>Tobacco Control Commissioner (MM)</p> <p>Specialist Public Health Nurse (FP)</p> <p>Health Protection Advisor (FP)</p> <p>Stop Smoking Advisor (FP)</p> <p>Stop Smoking Advisor (FP)</p> <p>Community Health Development Officer (FP)</p> <p>Principal Compliance and Prevention Officer (MM)</p>	<p>Site 4 – Teenage Pregnancy</p> <p>Teen Parents Personal Advisor (FP)</p> <p>Young Parents Personal Advisor (FP)</p> <p>Teenage Pregnancy Co-ordinator (MM)</p> <p>Specialist Midwife in Teenage Pregnancy (FP)</p> <p>Deputy Director of Public Health (Senior Manager)</p> <p>Children Centre Manager (MM)</p> <p>Choices Coordinator (FP)</p> <p>Consultant Midwife (FP)</p>

Four focus groups were conducted with service users composed as follows:

- the alcohol focus group in site 1 comprised 7 members, all male, aged between 18 and 50 with the majority in their 30s and 40s
- the obesity focus group in site 2 comprised 14 members – 13 female, 1 male with an age range from 20s - 60s
- two teenage pregnancy focus groups were held in site 4: the first comprised just 3 females aged 17 – 18; because of under-recruitment a second focus group was held comprising 7 females aged 16 – 18 and one male aged 18.

3.4 Developing research instruments

Interview guides were developed and piloted for the first round of interviews (phase 1). The interviews were semi-structured and on average took an hour to complete in each case. Separate guides were developed for the follow-up interviews (phase 2) and for the 4 tracer issues (phase 3). The interviews in phase 3 took on average just over an hour. The interview topic guides are provided in Appendix 2.

The 4 tracer issues were selected on the basis of identifying the top three public health national indicators derived from the health profiles for local areas published by the Association of Public Health Observatories for the Department of Health and from the assessments undertaken by the CAA. In site 3 smoking cessation services (NI 123 – stopping smoking) were selected as deaths from smoking was the top priority. In site 2 obesity (NI 8 – adult participation in sport and active recreation) was chosen as its reduction was a priority in the LAA. In site 4 teenage pregnancy (NI 112 – change in the under 18 conception rate) was a key problem identified in the LAA. Finally, in site 1 alcohol misuse (NI 39 – rate of hospital admissions per 100,000 for alcohol related harm) was a key problem and its control a major priority. In terms of performance assessed by the CAA, only one of the sites (site 4) had been given a red flag as a result of having a higher than average (for the region and country) number of teenage girls getting pregnant with progress having stagnated since 2000 with few signs of any improvement. In respect of the other tracer issue sites, site 3 on smoking cessation was in the best 5% of authorities in terms of performance but showed signs of deteriorating; site 1 on alcohol misuse was in the worst 25% of authorities but showing signs of deteriorating; and site 2 on obesity was in the highest 20% of authorities with no indication given as to whether performance was improving or deteriorating.

On the basis of these assessments, the four chosen tracer issues reflected a good spread of high and low achievers. However, in the end, despite numerous efforts at various levels, we were only able fully to complete a study of three of the tracer issues. Site 3, after months of procrastination, in the end failed to deliver the necessary access to the user group that had been identified. The paradox was that this particular site was in the high performing category for partnership working and enjoyed a national reputation for its efforts, winning awards for its achievements. Nevertheless, we were still able to conduct interviews with staff at various

levels so have been able to report on some aspects of progress with this particular tracer issue.

3.5 Interview analysis

Qualitative analysis of interview transcripts was undertaken using a Framework Analysis approach which identifies key issues and concepts through a thematic approach to the data analysis, informed by the interview schedule (topic guide) and subsequent analysis of the interview transcripts.⁹⁷ It has been suggested: '...the ways in which qualitative data are analysed are unclear in reports of findings'.⁹⁸ Consequently, this study also utilised the NVivo software package, a computer programme specifically developed to assist in the organisation and analysis of qualitative data and a valuable resource in the management of qualitative data.⁹⁹ Minimisation of some of the administrative tasks involved in the qualitative research allows for more time to reflect on the content of the raw data, and this encouraged deeper analysis of the data than would otherwise have been possible. Use of NVivo helps render the process of analysis more explicit and reflective. Computer assisted analysis can strengthen the conclusions drawn, by demonstrating that the analysis has been systematic, reliable and transparent.^{100,101}

3.6 Documentary analysis

For all nine of our field sites documentary analysis included the IDeA Healthy Communities peer review reports, LAAs, JSNA reports where available, DPH annual reports. For the tracer issue sites we obtained reports outlining their strategies in regard to smoking cessation, teenage pregnancy, tackling obesity and alcohol misuse.

4 Perspectives on Partnerships

As noted earlier, the aim of this study is to address a number of key questions in relation to public health partnerships, including:

- What are the determinants of successful partnership working?
- What are the barriers to partnership working?
- How effective are Joint Director of Public Health posts?
- What is the impact of partnerships and joint commissioning?
- What is the role and scope of partnerships in Local Area Agreements?
- What is the impact of partnerships on outcomes?

4.1 Interviewee accounts

In this chapter, we report on the key themes and issues emerging from the phase 1 interviews conducted in the nine selected sites as described in the preceding chapter. The structure follows the main sections of the interview topic guide (see Appendix 2).

4.1.1 Determinants of successful partnership working

The three factors most commonly cited by the interviewees to describe what constitutes an effective partnership were:

- a partnership that is clear about its goals and objectives
- partners that are aware of their roles and responsibilities
- a partnership that has a clear strategic overview of how it is performing through robust monitoring and evaluation.

Having a clear focus about what the partnership is there to achieve was seen as essential. It was believed that unless clear goals were stated from the outset then the partnership would lack focus. Allied to this was a view that each partner agency had to be clear about their respective roles and responsibilities and that these were clear to all other agencies. This could be achieved by a partner being responsible for a specific target in the LAA, for example, or being responsible for an element of a target in partnership with others. Close monitoring and evaluation of target goals was seen as essential to ensure progress remained 'on track' with remedial action being taken if there was a lack of progress. These two respondents encapsulate some of these themes:

'...what is it that both parties are trying to get out of their relationship, so there's got to be an end, an outcome for it, and that'll govern for me whether it's successful or not, so that's key. I think once you're both clear about your desired joint outcomes then it's about probably clarifying what

you each bring to the party. You know, what is it that you can contribute and what your partner can contribute, and you need to have a good understanding of each other's statutory responsibilities and other things and strategic priorities that you're trying to achieve so you can see their perspective whilst knowing that you're both trying to get to the same outcome. And underpinning all of that the strategic stuff is about having good working relationships and trust, and that's people getting to know each other, as people, and spending time with each other' (Deputy Director of Commissioning, site 6).

'I think one of the problems with partnerships in public health in the past has been very much that they're almost believed to be a good thing, an end in themselves, rather than having a real focus around...what's the meaning, what's the delivery, what are we trying to achieve. So first of all for me it works best for me when we're very clear about what we're trying to do' (Director of Civic Engagement, site 8).

History of joint working

Having a good history of joint working was seen as advantageous for a number of reasons:

- drawing on examples of best practice from the past to determine 'what works'
- although important, due to the established structures the partnership is less reliant on key individuals
- trust is built up between organisations over a period of time
- a culture of partnership working is embedded in organisations
- the above factors bring a maturity to partnership relations.

The chair of a LSP encapsulates some of these themes and the benefits a history of joint working brings:

'Oh it makes life a hell of a lot easier. I mean enormously easier. I mean I don't spend a lot of my time or virtually any of my time having to sit down and worry about some of the issues with the local PCT, such as cost shunting, and worrying about them trying to palm their problems off on us. Equally, the chair of the PCT, who happens to be an opposition councillor, you know, comes to see me regularly, she's not saying that she feels that she's got the problem of the Council trying to off load costs or problems onto them. So that immediately puts you in a good place because instead of being constantly at logger-heads over let's say cost shunting issues, which might hinder the way you go about the public health agenda, immediately we're...happy with the way things are going so we can have a...fairly frank and honest discussion about public health' (site 5).

One factor that facilitated a good history of joint working was having co-terminous local authority and PCT boundaries because this meant not having to work across two PCTs. A familiar factor which was found to be very disruptive to the sound functioning of partnerships was frequent structural re-organisations – often cited was the merger of PCTs and changes of key personnel in local authorities. These two respondents

encapsulate some of the difficulties associated with constant organisational change:

'I think certainly the structural changes in the PCTs where you've got people, you know, changing roles and it appears to me, certainly from the national support team visits that where you'd got some things that were working well, they're not working as well because there's been so much reorganisation. So I think that has created quite a lot of uncertainty. It's very difficult for partners to know who to work with, and that again is probably one of the reasons where they've got fairly giant under spends because, you know, their organisations don't understand what they're doing, they haven't got a close relationship with partners...' (Head of Culture, site 6).

'I think the biggest tension has been, to be honest, within the local authority with having to go through its reorganisation, three, four, five times, however many times, because it was targeted because it was poorly performing, and quite often there that did affect partnerships. You'd bring a new chief executive in, and they would get rid of a whole tier and then bring a new one in. And then, you know, there was another fall when it became the bottom in the UK and then a whole lot of people went, a new lot in. And in some ways I'd say that forced a sort of joining of minds, but it also affected the partnership because you often, you know, you got to know people or whatever and suddenly they weren't there' (Assistant Director of Commissioning, site 4).

Loss of an organisation's 'corporate memory' meant that partnerships had to start from scratch to re-build relationships with key personnel. This of course took time and joint initiatives, in the meantime, risked losing focus as a result.

The importance of goodwill between partners

Goodwill between partners was seen as very important in enabling effective partnerships. It engendered trust, respect, loyalty and commitment to go that 'extra mile' for each other. The following respondents explain why goodwill is so important in partnerships:

'...when I think about areas that are functioning more effectively, as opposed to areas that are functioning less effectively, I mean it's goodwill between agencies. It's also around genuine relationships between the people working, so they're working almost as if they're in the same agency, so there's a sort of shared sense of where they're going. I think partnerships that aren't going as well sometimes have a high priority but perhaps lack that goodwill or relationships to actually make that happen in a real sense, and then it just ends up on paper without genuinely moving forward' (Consultant in Public Health, site 5).

'I think they're based on relationships a lot of the time. I guess goodwill lies behind that but relationships seem more and more significant than goodwill because you develop a sense of obligation...you don't want to let each other down, it's professional shared responsibilities, and I think that

becomes stronger when you know who you're working with. I'm thinking about personalities here, you know, I would not want to [let certain people] down...because they are people that I respect and actually know that they would do the same for me' (Strategic Director, Children and Young People Services, site 7).

'...I think if you haven't got goodwill you may as well just not bother really, frankly. I think it's the only thing that keeps partnership working going most of the time. Because of lack of clarity about lots of other reasons why you're there, if people do not come with a positive intention to address the issues and to try and join them up across organisations, frankly, you may as I say you may as well just go home. So I think goodwill's critical' (Principal Health Policy Officer, site 7).

Although there was a general consensus that goodwill was essential and in some respects was seen as the metaphorical glue that holds partnerships together, there was also a recognition that robust policies and procedures, and partners being able to work together to help to achieve their own outcomes, were also reasons for engagement and commitment.

The role of 'local champions'

Having local champions was felt to be beneficial to partnerships in a number of ways. Their commitment and passion enthuses others which in turn attracts them into the public health arena in a variety of capacities. One DPH and a Consultant in Public Health from a different site describe how they have developed programmes to identify local champions in their respective communities as they recognise the impact they can have:

'We've got a fantastic person now who's leading on our community engagement who really does know how to fire people up, and we've had some great events this past year to warm people up into what the issues are and to get them on board. So yes we had an event to launch the health checks at which thirty people signed up to be champions, and those thirty people are now being nurtured by Jackie to help them to know how they can be champions, what they need to do, how they can encourage other local people, etc, etc. Bring people along to health checks or take people along to activities, you know, leisure centres and all those kind of things' (Director of Public Health, site 3).

'...we've got things like our health champions programme, which is running at the moment...That is designed specifically to identify people out in the communities and particularly prioritising the seldom heard groups so that they can actually act as conduits for them to be able to share with us what the health issues are, as perceived in those communities, but also for us to be able to tailor key messages in such a way that those communities respond' (Consultant in Public Health, site 5).

However, as already noted, over-reliance on 'local champions' can leave a partnership vulnerable if/when these people move on due to re-structuring, cessation of funding, career development or other reasons.

Which organisations are crucial in public health partnerships?

Apart from the LA and the PCT, the voluntary and community sector, the police, various hospital trusts (e.g. acute, foundation, mental health) and the business sector were seen as crucial partners in public health. In contrast, user and carer groups and GPs were infrequently cited. Within the LA, social services, education and housing departments were the most frequently cited. When asked which agencies or sectors were not involved in their public health partnership but which they felt should be, the most commonly cited were the business sector and GPs.

One respondent summarises why it was felt the business sector was an important partner:

'...we all agreed we need to get some representatives of the business sector. I think for a number of reasons. I mean partly that health and wellbeing, a lot of the promotion of that and initiatives around it, will come through people's work identities, and local employers can be quite powerful, and for me there's something about getting people to think health impact, and there's something in it for them as well, and it will be a different sort of impact between the big shops in the flash new shopping centre as opposed to organisations which maybe work within specific communities' (Strategic Director of Health and Adult Community Care, site 7).

It was believed having GPs involved in their role of being able to spread public health messages was important but it was felt by some respondents that GPs were generally disengaged from public health partnerships. One Director of Commissioning explained some of the benefits of having a GP on the partnership:

'...we've found a GP champion who will come to the partnership meetings and, again, rightly or wrongly, will get a lot more time and airtime than I will with the rest of the partners, with the wider population. It remains a truism that when we get up on a public platform, I can write the speech, but if the GP delivers it, it's a much more compelling case for the public. Inexplicably, they don't believe me' (Director of Commissioning, site 6).

Are all partners equally committed to the public health partnership?

There was a consensus that partners were generally committed to working in partnership. However it was felt that some partners needed to show more of a commitment and those most cited were the business sector, GPs, probation service, the police and acute trusts. As one Director of Commissioning acknowledged in relation to elements of the NHS:

'...across the PCT and the Council I think there's strong commitment from both sides. And I think probably we are equally committed. If you were to extend this to a wider group of stakeholders, clearly I think it would be fair to say there's probably less enthusiasm amongst those parts of the NHS which are about treating ill health, because clearly they see that they really need to do their own stuff to a degree. I mean they would recognise the need for investment in public health, but they would also feel that perhaps that they could utilise that money to treat people who are ill, you know,

better. I'm sure there are some issues there in terms of well they sort of support that, but as long as it doesn't get in the way of what they need to treat people' (site 3).

As mentioned earlier, it was suggested that the business sector and GPs needed more representation on public health partnerships as it was believed they could contribute to the public health agenda in a number of ways, such as GPs acting as 'local champions' and disseminating public health messages or through establishing private sport and fitness centres for example, and generally being more involved in promoting public health.

4.1.2 Barriers to partnership working

Various barriers to successful partnership working were identified and the key ones are considered in this sub-section.

Resources and partnership working

Given that the public health function sits with the PCT it is not surprising that many of the public health initiatives were largely funded by it. Other funding was usually drawn down from the LA or through bidding for specific initiatives. It was perceived that due to other budgetary pressures, LAs did not have significant resources to commit to public health initiatives, as these two DsPH illustrate:

'They're [the local authority] very strapped for cash and the PCT is in a very strong financial position, at least this year and next year, and where we've got external funding, we've had our LPSA [Local Public Service Agreement] reward grant or LAA money, what we've been doing is trying to use that to support partnership working so that if, you know, we know that the local authority won't be able to provide the funding, we've been able to use that resource to provide the funding. So there's a lot of goodwill there, there's a lot of, you know, the culture has changed' (site 9).

'I mean in the end what I'm doing is leading from the front. I will deliver a lot of these programmes with NHS mainstream money, and we will therefore have to ration cancer drugs, as we do, to pay for that. That's fine. On a cost-effectiveness basis I can do that. It's perfectly justifiable. You know, I have to be able to stand up and justify the balance in our financial strategy to the [PCT] Board of how we play that out. And despite grumblings about democratic accountability, not one person in the city council is prepared to tackle that breadth of agenda. When it comes down to rationing, oh its back to the NHS, you deal with that' (site 1).

In respect of pooled budgets, the existence of these was not extensive. Where they were referred to it was usually in regard to mental health provision. However, partners' deciding jointly where to target their resources was a more common feature, as this respondent explains:

'I think it's true to say that we've got very few real pooled budgets. We've got quite a lot of alignment. Some of the sort of longstanding ones, if I take mental health as an example, so improving services for mental health using the ring-fenced accounts grant that came down through the PCTs

three years ago...So although it's still sort of physically sits in the two different financial systems, it's joint decisions... So it's not pooled budgets but it's pooled responsibilities, pooled commitments for joint outcomes and so on' (Programme Director - Health Partnership, site 7).

One study area did have widespread pooled budgets and the Director of Commissioning related how they had been beneficial:

'I think in a nutshell one of the key things for commissioning...is that we see it as one big pot of money, and okay there are still separate legal entities but in terms of the approach it's sort of like one big pot of money. And I think that makes a very big cultural difference in the way that things are viewed. There's not the same level of conflict and tension as there is in many other patches where, you know, things like continuing care or the sort of transfer of resources from one to another under the new guidance around learning disability, for instance, causing angst and difficulties and a lot of mutual suspicion and disagreement, we don't have those kind of issues here at all. You know, we look at it and...it's about well how can we ensure that both sides of both organisational entities stay in balance, you know, achieve our duties and work together to deliver that. And it has an enormous difference in my view in the way in which we look at the world as a sort of combined health and social care, well now health and wellbeing, entity. So we've used pooled budgets very creatively to flex them over time, to use the flexibility of pooled budgets which has allowed us to have in some cases surpluses on the PCT side and surpluses on the LA side which has allowed us to manage the resources much more effectively. And certainly that's probably brought in about £3 million worth of extra capital...as a result of doing that' (site 3).

Are all partners aware of what constitutes health inequalities and public health?

Overall, it was believed there was generally a good awareness among partners as to what constituted health inequalities and public health. However, there were variations with different levels of awareness of various issues according to each agency's specialism. The voluntary and community sector was cited by respondents as being less aware than other sectors. Although respondents felt the situation was improving, it was believed that the voluntary and community sector tended to focus upon its own areas of concern (i.e. alcohol reduction) rather than focusing upon the wider determinants of health within public health partnerships. This respondent echoes some of these points:

'So I think the voluntary sector to some extent struggle around the broader health and wellbeing agenda. I think our acute trust is actually, I mean they're there to provide a particular kind of service, but again have over the last two or three years clearly been thinking about how they can have an impact on the stuff around smoking and getting people when they go in before operations and all of that kind of stuff, thinking about their staff more in terms of their health and wellbeing, but to some extent probably

still struggling, I mean in terms of the bigger picture stuff' (Partnership Manager, site 5).

However, as a Health Policy Officer argues, the terminologies used may mean different things to different people:

'I...think the whole term 'health and wellbeing' is fraught with difficulty in terms of people's understanding of what it means... it's become one of those meaningless words, much like the word 'partnership' has become very meaningless, in that it means different things to different people and none of them are specific. It's a general word used generally to apply to a multitude of things, which means if you're saying you're there to address wellbeing, actually what on earth do you mean?... people do just use terms assuming that everybody else in the room means the same thing by them. You very seldom hear people say what exactly do you mean by that? Very, very seldom, there's just an assumption that everybody understands, health inequalities, wellbeing, public health, you know, partnerships...people use those terms as though everybody means the same thing by them, and in my experience they hardly ever do' (site 7).

Lack of capacity of the voluntary and community sector

Although the voluntary and community sector was seen as crucial in public health partnerships, and examples were given of very good health initiatives by the sector, respondents did voice concerns over its lack of capacity on a number of levels.

The concerns chiefly related to smaller local voluntary organisations as opposed to large national charities such as MIND, Turning Point and so on and centred on the sector's ability to engage in commissioning for service delivery and on its reluctance or inability to engage strategically in partnerships. Although local authorities and PCTs, in accordance with national policy requirements, had put in place a number of measures to increase the capacity of the sector either through financial help or through providing support services, problems remained. The following respondents' comments expand on such issues:

'...it's [voluntary and community sector] not good at being able to deal with health and local authorities' means of providing services, because both local government and health are going to have to be held accountable for the funds they're spending...and as such there has to be a lot of governance arrangements in order to make sure that money is spent appropriately. And I think a lot of the third sector find that very, very difficult...they see themselves as a charity or do-gooders and when you start saying actually you have to account for that, or you've got to bid for this or something, they probably haven't got anyone in there that can put the bid together or whatever. So it frightens them off. And so that's why I think as health and local authorities we're not actually getting the engagement, and again it's something as an organisation we're looking at' (Assistant Director of Commissioning, site 4).

'I think we do work quite well with the voluntary agency both in commissioning services from them, and people like the Red Cross and Help the Aged and some of those bigger groups. What we've tried to do in the City, and it's only just happening now really is, we tried to encourage the local voluntary sector to become much more involved. And what we're trying to do as part of our procurement strategy is to make sure that there aren't so many barriers to entry for them. We've developed a market management strategy and a procurement strategy which have been agreed by the Board that really talk about how we can encourage local people. For sustainability and regeneration, we want to really bring local people in, but I have to say, it's not easy. We've commissioned our local CVS to work with us on developing a strategy for commissioning of the third sector in particular, and they're really keen. The bureaucracy, I'm seeing somebody this afternoon actually, the Chief Exec of the Hostel Liaison Group, to talk to her about how we would manage and work much more with the homeless community... So they're...keener and they have much less bureaucracy than the LA but I think the issue with them is that we don't know how to work with them very well and they don't how to get into us, so there is something, there is a barrier between us at the moment that we're keen to break down but we're nowhere close to doing that yet. We're only at the beginning of that' (Director of Commissioning, site 1).

'...they're [the voluntary and community sector] struggling with the thought of making strategic decisions as part of the...LSP as a strategic body...and they're struggling perhaps a little bit to come to that role. So we've done a lot of love and tender care to them to build up their capacity, and we put some funding their way to build their own capacity up. But they're in a transition period at the moment I would say, quite frankly. But in terms of delivery very good - you know, they're good at what they're good at but are struggling with the role of decision making or strategic thinking...' (Chair of LSP, site 9).

Political factors hampering partnerships

A moderate concern amongst respondents was the belief that political factors could cause tensions in partnerships. The predominant theme was councillors being wary of the partnership for fear of losing political and strategic control. Several respondents gave instances of this as in the following excerpts:

'I have to say, one or two cynical councillors who perhaps are the longer serving ones who have always been perhaps a bit suspicious of the underlying motives of the PCT...always a bit suspicious of their motives for 'let's work together' largely around resourcing of services and cost shunting which has been raised more than once in scrutiny, who should pay for what and we have pressures on our budget' (Acting Scrutiny Manager, site 2).

'I think there's widespread recognition of the need to work in partnership, and I think, certainly at an operational level, that's embraced. There may be some nervousness possibly on the parts of the politicians about perception, I suppose, of losing control and, you know, a need for them

more to develop a leadership or influencing role which has not traditionally been a strength of our members' (Deputy Director of Policy and Performance, site 4).

'...there's also a bit of friction between some of our politicians and partnerships. Not all our politicians like the word partnership because to them it means power being taken away from them' (Strategic Director, Children and Young People Services, site 7).

Partners' awareness of their roles and responsibilities

A common view was that not all partners were aware of their roles and responsibilities and, even if they were, their capacity to deliver on their commitments was questionable. LAs and PCTs were generally seen as being aware of their roles and responsibilities but it was perceived that some partners still saw their role in the partnership as an 'add-on' to their principal job with little sense of ownership by some agencies. Factors cited for this lack of awareness included a lack of definition in what was expected of partners, and lack of capacity to deliver, especially by the third sector. So, although it was believed that a partner being aware of their roles and responsibilities was seen as a key determinant of successful partnership working, in practice this was clearly not the case. As this respondent notes in regard to a lack of awareness of partners' roles and the reasons for this:

'...I think one of the reasons...is because we've always struggled to get health onto the agenda as something that the partnerships must talk about...because we haven't had a community strategy you see. It's basically been one of us saying we think health's important, would you mind discussing it at your partnership? And they will or they won't. One of the problems is that you've got to show somebody how they can contribute, not just in the abstract sense but in a real sense, and I don't think we've done enough. And I think the partnership's always struggled' (DPH, site 1).

Another DPH noted the following in regard to the willingness of partners to fulfil their responsibilities:

'Well I think they're aware of them, whether they actually deliver is something else. There's a subtle difference. They'll turn up to the meeting and say 'oh yes that's something we'll do', and then it doesn't actually happen' (site 2).

As another respondent wryly noted:

'Writing it on paper doesn't necessarily make it happen...' (Public Health Consultant, site 5).

For those who believed that the partner agencies were aware of their roles and responsibilities, the main reason cited for this was that there was a good degree of ownership of targets among partners and measures such as the LAA, and a partner being responsible for a particular target clarified what their role and function was.

A common theme was that the statutory priorities of an agency could sometimes distract them from full engagement in the partnership and hence

from a partner fulfilling their role. Such priorities included an agency's own or governmental targets to be met. As one Director of Commissioning noted:

'...I know what I can get sacked on, and it isn't for not delivering the LAA targets. If I don't deliver on 18 weeks, I don't sign the contract at the trust, then I'm in trouble' (site 1).

However, in light of this, it was also commonly believed that more joint priorities, targets and plans were being developed through such measures as the LAA and World Class Commissioning and it was hoped they would help more clearly to define partners' roles.

4.1.3 Effectiveness of joint Director of Public Health posts

There was a near unanimous view that joint DPH posts were effective for a number of reasons. Predominant among these were:

- the joint DPH acted as a bridge and a facilitator between the LA and PCT
- the post ensured that the public health priorities of the LA and PCT were joined up strategically
- the role helps break down cultural divisions between the PCT and LA
- with their knowledge of both the LA and PCT this would lead to more informed decision making.

These respondents echo some of these themes:

'[The joint DPH] has made a really big impact on just the way we think, the way we talk, the way we horizon scan, the way we think about problems or issues we've got to resolve, and so from that point of view has played a significant role in the development of the thinking of a council that's increasingly modernising itself' (Strategic Director, Children and Young People Services, site 7).

'[The joint DPH] can open doors for us. Joint policies, joint procedures, joint sharing of data, clear understanding around where are there tensions inside the council around some issues, and will that impact on us and can we ameliorate that, or do we need to put pressure back into the council in a different way, with... [the Director of Public Health] guiding us around, to make a change happen. So I think it's really beneficial to have a joint post' (Director of Commissioning, site 9).

'Something around joint accountability so that both organisations truly recognise their public health responsibilities, but also that both have a share of the public health resource and the influence that that post will be able to have on director level thinking, board level thinking of both organisations' (DPH, site 5).

However, there was the caveat that unless there was real commitment from both the LA and PCT to ensure the post is truly joint, and not just in name, then their effectiveness risked being undermined. Although not a principal theme, some respondents voiced concern that the joint post may involve the DPH stretching themselves too thinly across the LA and PCT. There was

also concern about how a joint DPH, funded jointly by the LA and PCT, would deal with any conflicts of interest between these two organisations.

LA and PCT cultural variations

DsPH discussed the cultural variations between a LA and a PCT, particularly how councillors have to respond to the local electorate in contrast to the democratic deficit and more hierarchical nature of a PCT. These respondents give a flavour of their experiences:

'In all kinds of ways it's different. In some ways the most obvious difference is that within...local government you're working within a democratic process in a way that you're not working in the PCT. You've got the whole cabinet system, the members, the scrutiny, and I'm just beginning to understand and appreciate the role and responsibility of these people. It takes a little bit of getting used to because they are in fact...very influential and very important, whereas...in the earlier days of the job I didn't really appreciate just how important it is in terms of providing leadership within the local authority, in terms of getting things to happen within the local authority, how very important the role of the members is. It's a very different environment from what you have in the PCT. I suppose also PCTs are in a way, there's a very strong and hierarchical authority from the Department of Health right down to the PCT level and indeed beyond. There isn't really the same, in the same sort of way that it's more diffuse within local government, it isn't so controlling' (DPH, site 7).

'...part of making good public health is communication, and... [because] public health [has been]... in the NHS for many, many years we have got into the NHS jargon, and it hasn't always been understood with politicians. If I want one of the politicians to increase the number of healthy walks and to spend more on their walkways and things, there's no point giving an academic argument, I want him to do more walks. You know, physical activity, this will get more people off your social services budget, keep more people out of hospital. I've got to give a really good argument as to why I think he should be putting money into improving the walks and getting more people out walking in the countryside for example. Or in children and families, there had to be a really good argument to get members to turn around their whole approach to sexual health services in schools, and we did that. And as a matter of fact in the full council they said why isn't the NHS putting sexual health service in all our schools? And we thought blimey. But that's what it takes to get to that point, for them to completely change. And it's amazing how powerful politicians are and they are the ordinary man on the street at the end of the day' (DPH, site 8).

Public health – more at home with a local authority?

Although not a major theme, respondents were asked whether the public health function should, as was the case before 1974, sit with the LA as opposed to the PCT. There was evenly divided opinion on this issue in regard to those advocating the pre-1974 arrangement and those advocating

the status quo. For those in favour of the public health function returning to the local authority, reasons given were that a local authority has more influence to set the public health agenda with schools, social services, community links and so on, and is therefore more embedded in the community. It was also believed that a PCT focused too much on a medical rather than a social model of health whereas in the case of a local authority the social model would be predominant. For those favouring the status quo, the line of argument was that partnership working arrangements and joint posts had become more embedded in PCTs and LAs thereby obviating the need for further change. It was also argued that such reorganisation would bring further disruption and upheaval.

4.1.4 Partnerships and joint commissioning

Work in progress is how respondents viewed joint commissioning arrangements. It was believed that joint commissioning was developing slowly and as a result, at present, was not as 'joined-up' as it should be. Problems included certain partners (most commonly councils) not being fully engaged in the process, as these respondents indicate:

'I think they're probably about average. I came from an authority where we were much more developed in our approach to joint commissioning, joint appointments for most of the areas. [The local authority has] been quite slow to develop. I think my perception is that it was reluctance on the part of the local authority rather than the PCT that's hindered progress. We have made some recent progress in terms of agreeing areas where we're developing joint commissioning more fully and so that has led to more joint appointments. We've just agreed to join our commissioners up at, well what's tier two in the council, so a tier beneath the Director of Social Services has just agreed to join those posts. So that's quite an important step forward for us because part of the feedback we've had about why joint commissioning hasn't felt more successful or hasn't felt easier for those that have been trying to work in that way is that it's not been joined in at a senior enough level in the organisation. So we've had joint appointments working at tier four but reporting to organisations. And basically they've just been doing sort of two part-time jobs as opposed to one really well integrated joined up agenda' (Director of Commissioning, site 7).

This Councillor also notes the lack of co-operation by their council in regard to commissioning arrangements:

'...I don't think they're well developed as they could be, and I think we've had a bit of a problem from the council side on this, and it's to do with commissioning of services and an understanding of what commissioning of services is, and it came about from the difficulty we've had in our council over the Chief Exec. Our Chief Exec had difficulties with...the Leader on where things were happening without his knowledge, and they weren't really commissioning they were actually contracts, so it's not the same thing, it's actually agreeing the contracts as opposed to commissioning the service and so commissioning was a dirty word in the council for a few months' (site 1).

A DPH also noted tensions previously between the LA and PCT:

'Joint commissioning, I would say it's not as well developed as we would like to be. I would say the area where it's most strongly developed would be around Children's Services, and it's been less well developed around Adult Community Care. Why? I think we didn't have the right governance structures around it. I think that there were tensions to a certain extent between the two organisations in that the PCT was hell for leather in going for a commissioning approach to things and a sharp division between our provider function and our commissioning function. I think there was certainly more ambivalence, if you go back a year ago within the local authority there was more ambivalence about how radical from a political point of view the council wanted to be in terms of becoming a commissioning authority rather than a big provider of services and so forth. I think there's been a lot of change in thinking about that in the course of the past year. So I would say that today the PCT and the council are much more of one mind about how we should be developing joint commissioning and are putting in place new structures around our LSP in order to enable that. So to make it more real and less sort of lip service and to make that, in a way the joint commissioning in particular so far as Adult Social Care was concerned was a bit of an add on, there wasn't core business. I think we're all agreed now, and it is rapidly becoming this is the way we do business' (site 7).

Other difficulties cited included the variability of commissioning arrangements where in some areas they were very well developed while in others this was not the case. These respondents cite examples of this:

'...on substance misuse there are national pooled budgets. So you can't spend the money without having a joint agreement and a partnership arrangement to do that. So joint commissioning there would be much more advanced than it would be around joint commissioning for stroke services, for example. The same drivers aren't there. I think where we've got more work to do certainly from our areas is around older people, and that obviously is a key area for social services and for the wider local authority in terms of wellbeing' (Deputy Director of Commissioning, site 6).

'I think we're getting there. I mean there's quite a few services that aren't integrated, but I think amongst joint commissioners I think we need to develop a clearer understanding of what our vision and aims and priorities are... And I think that's where we're focusing on. And bringing joint commissioners together because in one sense we are working jointly, but as a team we're in different departments across the council, but we also need to meet together as well to ensure that we're linked and our priorities complement each other. And where there are similarities, there are potential opportunities to invest more efficiently' (Health Partnership Manager, site 5).

Although not a major theme, there was evidence of commissioning being aligned with LAA targets. A Director of Commissioning and a DPH illustrate where there is strong alignment:

'...the LAA targets have figured in...terms of the commissioning strategic plan. So I think there's quite a good tie up...' (site 1).

'I think also we've got a very strong alignment between what we've got on the LAA and what the PCT has identified through world class commissioning as our priorities including within our strategic plan for the next three years and indeed for those areas which have been most challenging, the notable one I would say being teenage pregnancy and another one being the...obesity agenda, and we have already put in additional, a fair degree of additional, resources to make sure that we, as far as possible, will deliver' (site 9).

Part of effective commissioning is having a robust Joint Strategic Needs Assessments (JSNA). Overall, it was believed by respondents that their JSNA gave an accurate picture of public health in their area, although there were some concerns over gaps in the data. A Director of Commissioning states why the JSNA worked well but also where there were concerns over the quality of data:

'...we've got our first JNSA, and it's a real picture of information and data. It was a very joined up piece of work. The council and the PCT jointly appointed a project team to work on that, so it felt like a very joined-up bit of work. Probably, we took a view that if we only included that which we could have more confidence in, we'd have about three pages of a document. As it is, we've got 150 pages. A lot of which is very rich but is quite qualitative, quite subjective, almost anecdotal, but it tells a story and it puts that story into a single place. And I think already it is becoming the commissioning bible for commissioners in the local authority and the PCT ...' (site 7).

This Director of Health and Well-Being describes the process of compiling the JSNA and acknowledges there are gaps:

'I think it was a really good process. I mean I'm sure if you looked at it there would be gaps in it. But I think it was a process where we tried to use a lot of information from the council that had already been gathered around the sustainable community strategy and those sort of things so we didn't reinvent the wheel around some of that data. We used a lot of data that was available to public health but also the stuff that the hospitals and the GPs have and as far as possible we threaded all of those things into it. I think maybe what we need to do is that we probably need to map our providers a bit more systematically than we have done. But it was a very consultative process in terms of us going out to stakeholders and the general public around, you know, this is some of the things that the JSNA is telling us, does that feel right with you' (site 3).

It was generally believed that there was adequate co-ordination between partners in compiling the JSNA but there were areas of concern which revolved around the compatibility and sharing of data, as these respondents illustrate:

'The joint strategic needs assessment I think has been quite an interesting learning curve for everybody involved because there's a very different way of thinking about that. Actually, I have somebody in my team who's been working on it operationally, and she was just telling me this afternoon before I met you that one of the things that she'd noticed was that the council had an awful lot of information, but they used information in a very different way from the way that we do. And that they were through the JSNA process learning about how to use it to assess health improvement as distinct from simply performance outputs. And so one of the things that had happened was they had generated quite a lot of information that she then collated and analysed and fed it back to them, and they were quite surprised with what she'd done with it, because they hadn't realised that was possible with the data that they had' (Consultant in Public Health, site 5).

'There have been discussions going on locally anyway about data coordination and intelligence, and the need to improve the way we join that up, and that people should share information better. We're not very good at that...never have been. So, you know, the wealth of information that people like the public health analysts have got, for example, was not used well by the council or other agencies. The Joint Strategic Needs Assessment has been helpful because it's accelerated that discussion by making visible all of that data. Because that's what it does, it makes all of that visible, which means hopefully that an awful lot of people will use it, and they will use it not just for joint commissioning...' (Health Policy Officer, site 7).

Finally, as a Director of Commissioning bluntly noted:

'...we do have problems with data all the way through everything, through the Trust, through the hospital, through the PCT, through the council...The system that we have for managing data and sharing data is rubbish' (site 1).

4.1.5 Partnerships and LAAs

As described in an earlier chapter, the drive to tackle health inequalities in a local context in England is currently centred on LSPs and LAAs. The purpose of LAAs is to strike a balance between the priorities of central government on the one hand and local government and their partners on the other in reaching a consensus on how area-based funding will be used. The underlying concept behind LAAs is outcome-based and involves local government choosing up to 35 targets from a longer list of central government priorities. Local partners are then in theory left to decide how best to achieve these targets.

Have the LAA targets been agreed by all partners?

There was near unanimous agreement that the LAA targets had been jointly agreed by all partners. However, this did not preclude robust discussion and negotiation by partners for a particular target to be included or not as these respondents make clear:

'...the council may start to want to achieve different things potentially to the health side, and there is sometimes a bit of tension in discussion around that. But on the whole it's worked pretty well. As I say we got them through, they've all been jointly agreed. But nearly always it comes down to the ones that are going to cost the most money and where the money is coming [from]...' (Assistant Director of Commissioning, site 4).

'...how did we actually choose the targets that we've got? We started out with a very rigorous process, where we got the Board to agree that any targets that were coming forward for consideration for inclusion in the LAA had to be accompanied by a robust business case. That business case had to articulate a number of things like why was this [was] a priority...so we had a number of tests that people actually had to satisfy. And I have to say not all of the issues which officers from either the council, the PCT, police...thought it should be in the LAA, made the final cut. And a lot of that was because they actually could not convince the Board that this was something they really wanted to do. So there was a very, it was a very strong and a very robust business case process. We had some very lengthy sessions, workshops, somebody likened it to a 'Dragon's den' where the appropriate officer had to come in and sell the case. And some of them tanked and some of them got through, but it was always evidence based...' (Deputy Chief Executive, site 9).

It was generally perceived that at the end of the process the targets adopted by partners were agreed in a consensual manner. Disagreements centred around issues such as which partner, or partners, were responsible for the delivery of the target, what particular target should, or should not, be included, and ensuring that the targets matched with agencies' own targets, priorities and strategic plans. This respondent encapsulates some of these barriers to reaching agreement:

'The process has been quite difficult. It's been quite difficult because initially the political stance taken by the Cabinet was that it wanted a very limited number of objectives and targets within the LAA, and it wanted to be very confident that we could deliver on them...both within the council and among partners, the police and the PCT, particularly, were wanting many broader numbers of indicators selected within the LAA, and I was certainly arguing very strongly that I was wanting those things which were big challenges for us represented within the LAA rather than those things that we could do anyhow. So there was quite a long and quite difficult political process around what we were going to get in the LAA and what we weren't going to get in the LAA. And this was all taking place at the time of the change of the chief executive within the council as well, so it was all quite a difficult time. Anyhow, light broke out between us all. It was a good process, it wasn't a negative process, it was a process with a lot of challenges in it, but it didn't get into negativity and resentment and backbiting or anything, and we did come to a shared agreement across all the key statutory agencies with the Cabinet coming very much on board and then giving really strong leadership around making sure that we got

into the LAA those issues that were a problem for the City and that we needed to do something about' (DPH, site 7).

How well does the LAA align with other strategic aims?

A local authority's Corporate Plan and a PCT's Strategic Plan were the most commonly cited documents which had been informed by the LAA themes and targets.

How accountable are partners for the delivery of LAA targets?

Respondents cited a range of mechanisms to ensure targets were met, with lead organisations or directors or managers within a partner organisation accountable for delivering targets. However, a common theme was that processes were sometimes not robust enough to hold partners to account. This finding accords with issues reported earlier concerning the lack of awareness of roles and responsibilities, the oppressive bureaucracy in place, and lack of an outcomes focused approach in respect of policy delivery mechanisms. These respondents' comments describe some of the accountability mechanisms which featured in the delivery of LAAs:

'...we've got very clear delivery plans. We've got lead managers for every stream. We've got a separate performance management and monitoring stream that all partners are represented on, which we're actually strengthening at the present time to make sure the right people are there. So I would say that for partners throughout the lead agency for delivering, they are clearly aware of it and are working with those other partners who are important. So, yes, I think there's a very strong focus on delivering the LAA' (DPH, site 7).

'...each of our indicators where there was a business case that was put together [partners are] ...very clear about the ownership of it, who's the lead organisation, who's responsible for that particular theme and making sure that we getting regular reports through the partnership, making sure that the performance is being reported through in a very timely fashion' (DPH, site 9).

As noted, there was a concern that accountability mechanisms were not robust enough to ensure partners are accountable for delivery. These respondents' comments illustrate these concerns:

'...I was just having a discussion with one of my consultants yesterday, and one of the issues is, although they have responsibility for delivering on these targets, they are technically or officially not within the job description or necessary objectives of individuals within the council... our...joint public health consultant is having some issues around influencing individuals within the council to get them to play ball so that we can deliver on these agreed targets, and in a sense we were reviewing her objectives. And it almost looked like what we needed to have agreed at the outset with her was almost a work plan or an action plan specifically around influencing and engaging. Which for me, you know, I would have thought well if you've signed off these as your targets, and you've said, you know, these are, this is how it's going to be monitored, surely some names needed to have been

put in against these things so you performance manage people...' (DPH, site 2).

'I think, in principle, partners accept their accountability for delivery of the LAA framework. I think, in practice, it feels like it's not a very robust process' (Deputy Director of Performance, site 4).

'...I think the real big challenge that we've got is holding each other to account' (Deputy DPH, site 8).

In regard to scrutinising the LAA by council scrutiny committees, there was very little evidence of scrutinising the LAA per se, but there were instances of scrutiny committees focusing upon particular aspects of public health such as cardiovascular disease or obesity. There was a recognition that scrutiny committees needed to focus upon public health issues more and on the health related LAA themes as a whole:

'I think, to be perfectly honest, our scrutiny members struggle a bit with the LAA in how effectively to scrutinise it. We're beginning to get more dialogue with the partners at those meetings so the police as well have come in and the health people, but I think that more could be done to actually scrutinise the LAA effectively' (Acting Scrutiny Manager, site 2).

'I have to say that some councillors don't see health as very interesting, and it's because there's no political power within the local party group with it, if you see what I mean' (Chair, Health Scrutiny, site 7).

Will LAA targets have an impact 'on the ground'?

Two main themes emerged on this issue. First, for those who stated that targets would have an impact, the alignment of joint delivery plans and commissioning with the LAA, in conjunction with careful monitoring of targets, were seen as crucial. Second, and conversely, the lack of joined up delivery plans, of monitoring and of ownership of targets were seen as the key drivers mitigating against successful delivery.

Overall, at the time the interviews were conducted, there was a sense of cautious optimism in regard to some or all of the LAA targets being reached even though it would be some time before such a view could be realised (see next chapter on the follow-up interviews).

These respondents illustrate how joint delivery of targets was an important focus of the LAA:

'...the majority of our vital signs are in the LAA of what we've chosen. And what we did is we took the PCT strategic plan from the joint needs assessment, so we knew where our area is, and we actually targeted the 31 local authority [targets], the vital signs that are in the LAA that actually meet our strategic plan. Because that way it actually makes it easier to do joint working because you're both focused on the same thing' (Director of Commissioning, site 9).

'...we've got a very strong alignment between what we've got on the LAA and what the PCT has identified through world class commissioning as our

priorities including within our strategic plan for the next three years and indeed for those areas where there have been most challenges, the notable one I would say being teenage pregnancy and another one being the ...obesity agenda, and we have already put in additional, a fair degree of additional resources to make sure that, as far as possible, we will deliver' (DPH, site 7).

Lack of joint delivery and a deficiency of processes and mechanisms to deliver LAA targets are highlighted by these respondents:

'I mean I don't feel confident or assured about any of it really, and I think that...illustrates the point about have you got the systems and processes in place, because a part of that should be about giving you the assurance that things are working well. And I don't feel assured' (Deputy Director of Policy and Performance, site 4).

'I think that we can't work alone to try and achieve those [targets], and we need a much wider health community response to some of the issues, and at the moment we're very separate to it. We could say we work in partnership to tackle teenage conception but actually, city council do a bit, we do a bit, somebody else does a bit and there isn't one...team that sits there and deals with the whole lot. So I think some of them will have an impact. I genuinely believe that and I think if I didn't believe that, I wouldn't come to work. But I do think some of them are very challenging' (Director of Commissioning, site 1).

'So we just need to make sure that their action plans and our action plans, ideally we'd have one action plan between us, but at present I don't think things are as lined up – well, things are not having an impact so it's obvious that they're not as lined up as they should be. The other thing here is to say, if despite all the money we've invested in health over many years, we're not making any impact, perhaps we need to think about doing things differently' (Head of Culture and Health Services, site 6).

Those respondents who felt confident about the delivery of LAA targets highlighted in their delivery plans the joint nature and alignment of plans with other agencies particularly the LA and the PCT. Good monitoring and evaluation arrangements were also highlighted as key factors to ensure delivery of targets. On the other hand, the absence of these features in the delivery of targets was seen as the main reason for scepticism in delivering targets.

Respondents were aware of the tension between the long-term nature of addressing health inequalities and achieving public health milestones on the one hand and the three year focus of the LAA on the other hand. However, this was not viewed negatively as the LAA was seen as an indicator of the 'direction of travel' in reaching LAA targets which could then be adjusted accordingly in the next LAA. As this respondent illustrates:

'But if we've done all the right things, and it's going to take longer to deliver than the three-year LAA, I don't think anybody's going to be worried about that, because we are focused on fifteen years in the sustainable community

strategy. With the LAA in [the local authority] somebody cleverly said the sustainable community strategy is five LAAs. Some things will take five LAAs to change so breast-feeding may remain as an LAA target for three, six, nine because we may need to leave it there that long' (Director of Modernisation and Performance, site 3).

Monitoring of LAA targets

Three themes emerged in relation to the monitoring of LAA targets:

- there were a variety of policy mechanisms for monitoring the progress of targets
- there were sometimes difficulties in measuring targets
- more robust monitoring was required to ensure targets were being met.

A wide variety of arrangements in regard to the monitoring of targets existed with targets being monitored by an Executive Leadership team in one local authority. Progress was then reported to the health and wellbeing partnership management board. In another authority, the LAA manager oversaw monitoring and evaluation, while in another a performance management sub-group was responsible for monitoring. Where there were named individuals or groups responsible for monitoring it was felt the mechanisms in place were sufficiently robust. This DPH gives a flavour of the monitoring and accountability mechanisms in place:

'...one of the things that we've done is together we get funded a post within the central LAA support team at the Council to support our [health] block [of the LAA]. And we've also just appointed this health and wellbeing project officer really to support me as block lead to ensure that exactly that happens. So that each of our indicators where there was a business case that was put together being very clear about the ownership of it, who's the lead organisation, who's responsible for that particular theme and making sure that we are getting regular reports through the partnership, making sure that the performance is being reported through in a very timely fashion' (site 9).

Another theme was the difficulty in measuring targets. This could be because of the lack of robust data or because of the somewhat nebulous nature of the target being measured, as this consultant in public health explains:

'I think looking at some of those indicators, you do find yourself thinking well I wonder how on earth they're going to measure that? My favourite I think is the emotional and social adjustment of children in primary school, and you think mm. I forget exactly how it's worded, but you think now how exactly are they measuring that? Because that's quite a tricky one. I don't think we're using it in our mental health ... because I think we'd looked at it and thought that's a bit approximate for us. Although you could say it's relevant, but how do you measure it? You know, there are clearly people whose job it is to sit down and think about these indicators and then create them. And I have certainly been in the business of saying, in previous

years, okay, you've asked for this information, but actually it doesn't exist at the moment in the form that you've asked for it. Oh, but we must have it. So what you then get is varying degrees of fiction, which is of no use to anyone. And that is, what you've got there is the dislocation between people at the centre who think they know what's available and people on the ground who can tell you what's available' (site 5).

Finally, although not as predominant a theme, there were some concerns about lax monitoring arrangements and the lack of accountability for reaching targets. This respondent's assessment encapsulates some of these issues:

'...it should be the LSP Leads Group that receives the reports...and says okay, you know, what are you doing about that? Which to some extent they're doing, but it's not affecting an improvement in performance. So it's not working well...I would like to see more rigorous feedback and reporting through the LSP Leads Group, so that there is an expectation at every meeting that the Chair of that particular board updates on exactly what has been happening in that area and gives assurance that the right actions are in place to deliver the targets, and that would be backed up by performance trend information that shows in fact yes the actions we're taking are impacting on our overall direction... So in terms of...please may I have your plan to deliver, sometimes we get a response [from partners], sometimes we don't, and there's no, you know, there's no sanction for not responding. If anything, I suppose what we get from the partners is this degree of undermining around, you know, don't you trust us to deliver, we've got our own plans we're doing, what do you need to know - that sort of response really, rather than good let's be open and yes we understand and, you know, we're transparent and we would actually like some help delivering this and what other support can we bring to bear. We never really get beyond those discussions of, you know, everything's fine or I don't actually know what the problem is' (Deputy Director of Policy and Performance, site 4).

The pressure (or temptation) to include 'quick wins' in the LAA

It was unanimously believed that there was no pressure and, indeed, no desire by partners to put 'quick wins' (targets that could easily and quickly be met) into the LAA. In fact, respondents complained that the opposite was the case with, in one instance, the Government Office insisting on including targets that were not achievable. As this Councillor states in relation to putting 'quick wins' into the LAA:

'As a politician I'm not in the ball game of quick wins. I'm in the ball game of achieving things. And I want to be fairly truthful in this endeavour. So, you know, I might win an election on a quick win but we've got to be very careful that you don't fall into that trap, and I don't think I want to do that actually. So the things that we've got on the LAA, like childhood obesity, teenage pregnancy, heart problems with the over 60s, are all ones that I think are correct. But as for spinning the quick wins, you don't come to me' (site 7).

In relation to the pressure from the Government Office insisting on a particular target being included, this Deputy Chief Executive gives an account of the process:

'Some of the targets that we ended up with are much more stretching than we wanted, and I've told Government Office we can't deliver it, we will not do that. Well I'm sorry we won't accept a target of less than x, and I said well it's farcical, we are not going to [do it]. And not just because it was too difficult, but we gave them trend based evidence of where we'd been, even in the most likely predictions what else we could do, and it was just unattainable, and we've told them that but the targets in there. So in some respects we set off to fail before we start...' (site 9).

Pressure from Government Office for either a particular target in the LAA or for a percentage reduction for a particular target was a recurring theme. As this respondent makes clear:

'I mean it's challenging if not ridiculous in the sense that we haven't budged from really where we were ten years ago, [on teenage pregnancy target] and now we, I mean we had a 2.6% reduction last year against our ten year ago baseline, and we're expecting to go, we're expecting a 26% reduction - I mean, you know, just do the sums really. It's sort of short of standing around with condoms on the street corners' (Strategic Director, Children and Young People Services, site 7).

In some cases partners were able to negotiate with the Government Office a compromise on a particular target being included or for a less onerous percentage reduction in a particular target. Nevertheless, pressure for a particular target or a certain reduction to be made to a target was a common feature.

4.1.6 Partnerships and outcomes

Three themes emerged on this issue:

- policy and procedures were too bureaucratic
- the bureaucracy meant time delays were inevitable in decision-making
- it was believed that policy needed to be more outcomes focused.

With a range of partners, and the amount of co-ordination required among them to fulfil their activities, respondents believed that a degree of bureaucracy was inevitable. With a plethora of action plans, strategy documents and meetings it was believed that partnerships could become 'bogged down' in process issues with the attendant danger that they would lose a focus on outcomes and become little more than 'talking shops'. These respondents echo some of these concerns:

'...sometimes you sort of get a subgroup of a subgroup of a subgroup that has still got to have everybody around the table and it just becomes paralysing' (Programme Director - Health Partnership, site 7).

'You know, most people don't give a toss who provides a service, most people only really want a service that meets their expectations. Most people are actually very ignorant, and I don't mean that in a pejorative sense but uninformed about the way local authorities, PCTs, other organisations, and it's not surprising if we look at the complexity of it, it's difficult enough for us to work out what each other does' (Deputy Chief Executive, site 9).

'...but at the moment everything we try and do is wrapped up in so much bureaucracy that goes back to the hierarchy and the council that it just delays everything. And that sort of encourages partnerships to break up, because I mean I'd be the first to say 'oh don't bother, just let's do it, let's just get on with it', otherwise we're never going to get anywhere, because it will take us six months to go that route, if we do it ourselves we can do it in three. So that's the biggest sort of knock on partnerships that there is really, when you know things are going to be delayed so much' (Director of Commissioning, site 1).

'...I think you get a lot of discussion about process, and people are very interested in the process, but it's actually pinning down what is the system we're going to put in place to measure these outcomes, and I think that is a real challenge actually' (Director of Public Health, site 6).

Given the complexity of the policy process and the difficulties in ensuring partner agencies were aware of their roles and responsibilities it is perhaps unsurprising that respondents believed that, as highlighted earlier, a large amount of goodwill between partner agencies was the 'glue' that held partnerships in place and enabled them to overcome the barriers they faced.

Could health outcomes be achieved without working in partnership?

The near universal response on this issue was that health outcomes could not be achieved in the absence of partnerships. There was recognition that because public health issues are multi-faceted and complex then a strategic and joined-up approach was needed to tackle these commonly termed 'wicked issues'. There was also the view that individual agencies did not have the capacity to deliver public health improvements on their own and that it was only through combining resources and having a joint delivery strategy in place that agencies could together make an impact. These respondents illustrate these points:

'...we don't have the capacity, and I think there's something about what other partners bring. Because we always wear the health hat, but the local authority brings education, employment, loads of other things and the voluntary sector bring a whole different perspective too, and a partnership is about joint working, it's not one person doing it all. It's a bit like a marriage really. So there is no one solution to these problems, to these health inequality public health problems...' (Director of Commissioning, site 9).

'...we [local authority] might be very well placed to pick up issues around teenage pregnancy and issues around sexual health and obesity in schools because of the sort of outreach that we've got through the school networks and other things. But there still needs to be that referral on at the end of the day to a health professional. So therefore we are always going to need in my view partnership working. Unless we ever reach stage where central government decides to devolve all health functions, acute and otherwise, to local authorities, which I don't think will ever happen, and I don't think it's desirable anyway. There's always going to be a need for partnership working because we can't deliver the medical outcomes, the PCT can't deliver the access to many of these people on a regular basis to be able to get at those problems, but together we can' (Chair of LSP, site 5).

'If you mean without partnership by working in separate silos we can achieve those goals, I think that's exceedingly unlikely' (Consultant in Public Health, site 5).

Are outcomes delivered by the partnership?

Respondents were questioned on how they could be sure that it was the partnership that was having an impact on the delivery of targets and agreed outcomes as opposed to an individual agency. Three themes were predominant:

- respondents did not know if it was the partnership that was responsible for the delivery of outcomes as this would be difficult to measure or quantify
- through the accountability mechanisms in place it could be seen which agencies were delivering
- as long as the desired outcomes were achieved it did not matter whether they were delivered by the partnership or not.

On the issue of respondents not knowing if it was the partnership that was responsible for the delivery of outcomes as opposed to a single agency as this would be difficult to measure or quantify, the following respondents discuss the difficulties:

'...how do you know whether it was the partnership that delivered it? And the only way you could really test that is to...apply the definition of causality to the outcome, which would be slightly difficult wouldn't it because you could...go for a major impact on say all age all cause mortality and have a chance occurrence of a real drop in the number of deaths for some reason, and you would never know that' (Deputy DPH, site 8).

'...we need to first be clear about what's bringing about the changes in our outcomes. I'm not sure we're clear enough. Take teenage pregnancies, you know, there's about four or five key strands to that programme, and we see an improvement, but I'm not sure we could say which one of those four or five strands was delivering that improvement. Some of it relies on the partnership, some of those don't, but it would be quite hard to isolate whether it was the partnership that was giving them success' (Director of Commissioning, site 7).

There was a belief that the partnership was responsible for the delivery of outcomes and this could be identified through robust monitoring and accountability mechanisms. Although less predominant, there was also a view that the partnership acted as an enabler for the delivery of outcomes, as these respondents make clear:

'I suppose it's by being clear from the outset what contribution each has to make. I think sometimes people just think by getting around a table they can achieve something rather than working through those assumptions. So being clear about what it is that you're trying to achieve, ultimately the outcomes you're aiming for, and if that's the outcome what are the preconditions that you need to achieve it. When you start really breaking down what the preconditions are sometimes it becomes clear which are the agencies and partners that will have the biggest impact on that precondition. So I think if you've done that work beforehand it is easier to measure whether the partner is playing the role they're supposed to make. But quite often people don't do the pre-work' (Deputy Director of Commissioning, site 6).

'My view is as long as you're delivering the outcomes, I would always argue that an enabler to that would be the partnership because the partnership outcomes are that you've got a much wider - you've got the resources of both organisations that can help you to achieve things and you've got a much better strategic tie up so you haven't got two organisations fighting against each other...' (Director, Health and Well-Being, site 3).

There was a view that it did not matter if the partnership did not deliver the outcome as long as the outcome was delivered:

'As long as you're agreeing between you what the metrics are, what the baseline is and what you're measuring, and you agree between you that that's what's going to, if you see a shift that's going to be success, then I think that's probably as good as it gets isn't it' (Director of Civic Engagement, site 8).

'...I'm not actually that fussed about whether it's the partnership that delivers it. I think, you know, it's a bit apple pie...' (Director of Commissioning, site 5).

Given the differences in opinion over whether partnerships could be identified as the essential ingredient for achieving tangible health outcomes, it may come as no surprise that it was argued that better monitoring was required in terms of partnership delivery to see 'what works'. These respondents are typical in relation to this view:

We've got [a] culture and wellbeing LSP theme group, and the council's been, well, it's been one of three local authorities who have been piloting a number of quite high profile wellbeing themes or wellbeing interventions. I think there's a couple of others in the country, so...[the local authority] has been nationally recognised for its wellbeing initiatives. I haven't worked with them for a long time to know where it all sort of came from I suppose in the sense of the detail, but we are now getting to the stage where people

are asking questions about measuring the outcome. I mean they'd been running a couple of years, I don't know, or a year, two years some of these things. And I think as individual projects there's a number of elements to it. Some of them have probably better measurement than others, but on the whole I think that is the area that we struggle with, and we were just talking about literally measuring wellbeing. I think everybody's perhaps doing some kind of measurements of their own, but you talked about trying to have a more common agreement across a number of these initiatives to measure similar things, you know, and that is where we need to get to. There was sort of agreement that's where we want to get to, but we need more work to do that' (Acting DPH, site 6).

'I think whatever partnership you've got it's about somebody with leadership having focus, what are we here achieve, how are we doing? Now that question how are we doing, it hardly ever gets answered, and I've really struggled actually to get the whole of my public health information people to answer that question. Give us information, how are we doing on inequalities?' (DPH, site 8).

The bottom line – are the resource costs of partnership justified in terms of outcomes gained?

Given that partnerships are not cost free, since they incur significant resource costs to establish and maintain (both capital and human resource costs), respondents were asked whether they felt partnerships justify these costs in terms of the outcomes gained. A qualified 'yes' was the most common response to emerge, with respondents believing that partnerships do justify their transaction costs in terms of outcomes gained. However, as indicated, this view was qualified by a number of caveats.

First and foremost, respondents believed that with agencies working together partnerships removed duplication and channelled resources more effectively. There was also a view that partners such as LAs and PCTs would be working on common themes to improve public health and therefore it made sense for them to do it together for the aforementioned reasons. Partnerships were also seen as more able in leveraging resources for specific initiatives rather than through agencies acting alone. There was also the recognition that some public health issues were complex and multi-faceted and required a co-ordinated approach by different disciplines since they could not be tackled by an individual agency. Therefore, agencies had to act in concert to address these issues. These respondents are representative of these views:

'I think what we do know is in learning to work together across boundaries we are aware of lots of duplication that's gone on over the years which can only represent major wastage of resources, and things that we've done for years that haven't had an impact either. So you could argue that the learning that comes from, you know, learning to work in partnership because we know more about who's doing what and why and how, we should have the capacity to provide more value for money at the end of the day and better impact. Whether we do or not remains to be seen, but we

should because we do know more now and we do know that we are doing some crazy things and have been doing crazy things for years' (Strategic Director Children and Young People Services, site 7).

'For something like smoking it's easy because it's such a huge issue and by far the most important health inequality's issue in the city - you know, five hundred people a year die of it, 50% of our health inequality is smoking. There can be no doubt that [it] is the... most important thing of all, and because of the scale of the task it has to be a partnership agenda. It cannot be done, almost irrespective of the cost benefit...however much time I'd have to put into that, I would put it in because in the end it's the most important thing I can deliver. Now that's knowing that the intervention or knowing that the effect of the outcome has such a beneficial effect on health' (DPH, site 1).

In relation to smoking cessation, a DPH argued that the health benefits for the population far outweighed the costs of partnership and asked the rhetorical question *'...what is the cost of getting a smoking quitter?'* (site 8). In other words, the possible savings from a person stopping smoking and the health benefits to that individual and the potential savings on treatment by the NHS outweighed the costs of partnership.

These respondents echo the theme that health inequalities are multi-faceted and complex and therefore require a partnership approach in order to address them:

'...clearly there is a cost, and none of this is free. None of this is without some difficulty and some pain. It would be much easier on occasions for us as a local authority to say we will go off and we will run a campaign around obesity, couldn't care less what the PCT think about it. But, you know, it's okay us putting out messages around obesity and healthy eating and everything else, but if there's not the back-up there from the PCT in terms of clinics only run for people who are obese, you know, healthy eating packages and all those other things, then it's not going to work. So, there is a cost, and some people would say that cost is too high. I would actually say that because it improves the outcomes to have that clear message going out from all the partners, that investment in bringing all that work together is money well spent' (Chair of LSP, site 5).

'...some of the things that we're trying to resolve and address through partnership working, as far as we can see there isn't any other way of addressing some of these very complex issues other than by through partnership working. So either we agree that we're not going to address these issues, or we do address them in partnership' (DPH, site 7).

As mentioned, although respondents by and large believed that partnerships did outweigh their transaction costs, there were a number of caveats. Predominant among these was that the partnership had to be seen to be delivering on its agreed outcomes otherwise their costs were not justified. These respondents echo these concerns:

'I don't think partnership working is de facto, a good thing. It is only a good thing if it delivers results, outcomes, whatever you want to say. And in some senses the test of the new Health and Wellbeing Board will be delivery of the LAA targets and other things...' (Strategic Director of Health and Adult Community Care, site 7).

'Well, I suppose...it all comes back to what the aim of the partnership is if the vision's there and does it deliver it? If it doesn't deliver what you want, and it just becomes a talking shop and I've been on many groups like that, where it just, they're not cost-effective and they're not a good use of anyone's time or anything. Where there is a clear vision and a clear outcome they can often be very cost-effective' (Assistant Director of Commissioning, site 4).

Although not as predominant a theme, some respondents found the question difficult to answer because the transaction costs of partnerships had not been factored into their cost calculations, although there was a view that such costs were not that high as partnership working was part of agencies' everyday activities and therefore was not seen as an 'add-on'.

What public health outcomes have been achieved through partnership working?

Respondents were asked what initiatives had been successful in tackling health inequalities and improving public health through working in partnership. Two main themes to emerge from the interviews were: (a) that the partnership was on track to deliver on a variety of public health outcomes but these had not as yet been achieved or may not be achieved; and (b) that discernible outcomes had been achieved through working in a collaborative manner.

A variety of projects in the public health arena were cited to demonstrate the value of partnership working, with alcohol reduction, smoking cessation, obesity and teenage pregnancy to the fore. These respondents give a representation of where they believe outcomes (against projected targets or delivery plans) had not been achieved hitherto but were on course to be:

'Okay, go with teenage pregnancies. If we hadn't worked with the local authority to help get the school nurses into the schools and to start dealing with sex education and giving out contraception and being available, we would not be on the road to sorting out our teenage conception targets. We couldn't have done it alone because this had been going on for years...and I'm told the headmasters were very reluctant to have nurses in the school who did anything but nursing. You didn't do health education or public health stuff at all. It's only by starting to do the local partnerships that this is being addressed, and we're starting to see a difference for those girls' (Director of Commissioning, site 9).

'...teenage pregnancies is one where the will is there, the partnership is there, but the facts on the ground tell you that the message ain't getting

through, and we've got to try and think of where we can sort of move on and work better' (Chair of LSP, site 9).

These respondents identify where they believe discernible outcomes had been achieved through working in partnership:

'...we've got a programme...called Activity for Life, which is...jointly funded by the PCT and the council, and it really is about, it's a GP referral programme for those people who are at risk of...CVD [cardiovascular disease] and particularly the over 50s, and it's actually...getting them into a healthier lifestyle and everything else like that. And it's an absolutely fantastic programme not only for their health but for their wellbeing as well. I've spoken to a number of... these people on a daily basis because I'm...in the sports centre every day myself, and I speak to these people, and all of a sudden they've realised that there is a life outside of morning television. But these people used to get up on a morning, go out and do a bit of shopping and come back and be watching Judge Judy on the television. And all of a sudden they're now going to the gym, going out for walks, you know, they've got a whole new circle of friends, people that they didn't know' (Health Scrutiny Chair, site 3).

'I think there is good evidence that the partnerships do deliver. So for example teenage pregnancy is a good one where we've got a...teenage pregnancy partnership which is hosted through the... [local authority] with good health buy-in, and the one area that they really focused on and did a lot of work on the ground, so almost community development type role of going out and finding out what people wanted and needed and then commission that, we can show that that's really had a major impact on the rate in that local district. And what we're doing now is making sure that we're replicating that same sort of process in the other districts to emulate the reduction in teenage pregnancy...I guess another one taking it the opposite would be healthy schools, which is a county target but we've put in the staff on the ground to support the delivery of healthy schools in each of our schools. With good success, I mean we're pretty much ahead of the national targets now on delivering healthy schools' (Deputy DPH, site 8).

'I think certainly teenage pregnancy would be one where we were aware that we'd got very high levels of teenage pregnancy in one area in the borough...which is also an area that the council was concentrating on because New Deal for Communities was in that area. And so because of our partnership, we were able to influence a new way of working around teenage pregnancy which was to get all of the partners who in that area were working with young people to come together and devise a strategy which was really to get upstream of identifying what some of the risk factors would be around teenage pregnancy and then, you know, sort of really homing in, if you like, on those particular girls and their families and try to sort of turn them around. And it gave us some really, really good results and it's led to teenage pregnancy in that area coming right down and we're now using that as a sort of a model to look at other areas' (Director of Health and Well-being, site 3).

Although not a predominant theme, what might be termed 'process issues' were on occasion cited as an outcome inasmuch as the structures and policies were seen as an outcome in themselves as distinct from being the mechanism to deliver the outcome. This entailed respondents citing such things as good attendance at strategy meetings and drafting policies and procedures jointly with partners without defining any concrete examples of outcomes achieved through joint delivery.

4.1.7 The relationship with central government

Given what we said in an earlier chapter about the relationship between central government in terms of its ability to be joined up (or not) and the impact locally, respondents were asked what help and guidance was required from government to assist and support public health partnerships and measures to progress public health in general. A number of themes emerged but the predominant one was a desire for national government to leave LAs and PCTs alone to get on with delivering on the public health agenda. Respondents cited too many initiatives, too many government targets, too much PCT and other public sector reorganisation, and an over-bearing 'top down' policy approach from government as having a detrimental effect on public health practitioners and partnerships, preventing them from fulfilling their roles and responsibilities. These respondents encapsulate these concerns:

'I don't know, I don't know, be nice if government just went away for a bit wouldn't it really because it's so hands on and it's so frenetically into changing everything every five minutes that that's part of what drains the system a lot' (Programme Director - Health Partnership, site 7).

'I think the main thing that I think is the biggest constraint for us all is central diktat about what you should be doing locally. So we are, being absolutely candid, we're spending an awful lot of effort on some targets because we're not meeting them. Where if we were actually consulting with our population locally, they might have a different view about what we should be working on, and I don't think we are allowed to even take that into account. Government says that we must do this, this, this and this, and then if you've got any time left you can do anything you fancy locally. But of course it's not just time, it's also money. And if the money is tight and there is a target attached to it which takes us back to where we started, then that's where the priority is. So if money is tight then people will scale back on things that aren't target related before they'll scale back on the things that are... But we've now moved to the stage where we are so target driven that actually the room for being either creative or responsive to new issues just doesn't exist anymore. And things that we should be paying attention to aren't getting attention because it's crowded out by must-dos that are centrally dictated' (Consultant in Public Health, site 5).

Although not as predominant a theme respondents would like to see more joined-up policy responses from national government and argued that different government departments were on occasion at cross purposes or

appeared contradictory in their policy goals and objectives, as these respondents make clear:

'I'd like to see a consistency of vision and that vision sustained rather than things chopping and changing. I'd like to see less contradiction between different departments of state and critically I'd like them to stop reorganising the NHS' (Deputy Chief Executive, site 9).

'...the government does talk a lot about working across government, linked up government and all this sort of stuff. I think we really do need to see more of that in reality' (DPH, site 7).

Apart from changes in regard to policy, respondents also wanted to see help from government in the form of more resources for public health in general, for government to tackle the sale of cheap alcohol, place less emphasis on acute care and more focus on the public health agenda. These themes are summarised by these respondents:

'I think there should be more money, and I don't always agree with throwing money at everything, but you can do more if you have more people doing things. And so I do think that we need more money, we need more staff, I mean I know, [the Director of Public Health] here, has a very small staff, far too small for what they should be doing. And I do think that...government cannot expect authorities such [as us]...who are always strapped for cash...it would be interesting for them to put some extra money in and see what it actually brought. And it can't be chicken feed, it's got to be a reasonable amount of money' (Scrutiny Committee Health Lead, site 4).

'Well, I suppose, I'd say resources wouldn't I, but we won't get that' (Acting Scrutiny Manager, site 2).

'I'd like to see them starting to tackle the alcohol industry more because they're not. And you and I know that Christmas is coming, and we've already got Alan Hanson talking about you can get 3 for 1 at Morrison's already, you know, and you're thinking oh my god' (Director of Commissioning, site 9).

'Now I do think the government's talking about, it's talk, I don't know how far it's gone, about intervening to do with selling, reducing the low cost alcohol, and so I think that can only be a plus myself...' (Chair, Health Scrutiny Committee, site 9).

'...shifting the focus from acute care...I mean there's been some recent work done by the Department of Health looking at...promoting older people's partnerships. It's sort of health and wellbeing initiatives, usually jointly health and local authorities for older people, and what they found is that a pound spent by the local authority on prevention can save £10, or whatever the figure is, in the acute system. But actually there is something there very important about joint funding and where the money goes. So I suppose it's that whole area of resourcing and capacity' (Strategic Director of Health and Adult Community Care, site 7).

4.1.8 Future priorities

Finally, respondents were asked what their future priorities were over the next two to three years in regard to public health and partnerships. The main priority to emerge was to achieve the targets and goals partnerships had been set, or at least be well on the way to accomplishing these goals. Commonly cited were targets on smoking cessation, alcohol reduction, teenage pregnancy, obesity and reducing the mortality rates between wards in local authority areas. Other priorities included more emphasis on social marketing, improving commissioning, and ensuring the voluntary/community and business sectors were more actively engaged in partnerships.

4.2 Discussion and emerging key themes

Little is currently known about public health partnerships, despite the fact that collaborative working is a key competency of public health practice and partnerships remain high on the government's policy agenda. Even less is known about how effective partnerships are in achieving public health outcomes and tackling health inequalities.

From the first round of interviews reported in this chapter, although partnership working was regarded as the only or preferred way to tackle the multi-faceted nature of health inequalities and deliver improved public health outcomes, there was a clear recognition that working in partnership was not unproblematic. Partnerships were often seen as too bureaucratic with not all partners aware of their roles and responsibilities. This was sometimes combined with poor policy and management mechanisms to hold partners to account. Even though LAAs were designed in part to ensure an approach focused on outcomes, it is clear that this has not universally been implemented with evidence of a lack of delivery mechanisms to ensure policy is outcomes focused. Policy and procedures need to be more streamlined with an emphasis on outcomes rather than on the policy process itself. As has been shown, those partnerships deemed to be successful were those in which the policy processes were outcomes focused, with joint delivery mechanisms, clear lines of accountability, the full engagement of relevant partners, and where there was careful monitoring. Conversely, less successful partnerships were deemed to be deficient in respect of these key features.

It is important, therefore, that agencies are aware of their role and function within the partnership and that their responsibilities in achieving agreed objectives or targets are clearly set out. It is also essential that the objective(s) or target(s) adopted by a partner closely align with their own targets, priorities and delivery plans as this avoids duplication, streamlines delivery, and ensures a 'win-win' scenario for both the agency and the partnership as a whole.

Although, the former government's emphasis was on targets, as has been seen, there is a danger that targets can encourage both a short-term

approach to the policy process and reinforce a silo mentality among agencies thus rendering partnerships not as effective as they could be.

Joint posts have been claimed to be a valuable aid to partnerships which help bridge the gap in terms of policy delivery and facilitating joint working between LAs, PCTs and other partners. We comment further on these posts in subsequent chapters.

The absence of pooled budgets has arguably mitigated against delivering policy outcomes and more pooling of resources and partners identifying joint targeting of resources for specific initiatives would perhaps contribute to the delivery of outcomes. However, a recent report by the Audit Commission¹⁰² in regard to joint financing across health and social care found very little evidence that pooled or aligned budgets had much impact in influencing outcomes across a variety of health and social care settings.

Joint commissioning is still seen as 'work in progress'. More of it is perceived to be needed particularly with relevant council directorates and other key stakeholders to improve public health outcomes, including the voluntary and community sector (although issues of capacity in this sector need to be recognised). It is also apparent from many of our interviewees, including DsPH and directors of commissioning, that commissioning has to be more closely aligned to key delivery plans such as the LAA, PCT strategic plans, vital signs strategies, local authority corporate plans and community strategies. To aid commissioning, JSNAs need to be able to give a more comprehensive picture of local health needs and a key part of this is through ensuring that the various agencies' data are more compatible to enable sharing.

It is clear that much good work has been done and needs to continue in engaging smaller local voluntary and community sector organisations in public health partnerships where they are perceived to add value.

Our research at this point has shown that through bodies such as LSPs and initiatives such as the LAA, together with their alignment with corporate plans and community strategies etc, there is a danger of partnerships (already complex by their very nature) becoming too weighed down through burdensome and cumbersome processes and structures to be effective.

As noted at the start of this chapter, the first round of interviews has sought to establish some baseline issues in regard to partnership working in public health as identified by our interviewees across nine LSPs/LAAs in England. The subsequent phases of the research are designed to test and explore some of these issues and claims in more depth and at different points in time in order to lend the study a dynamic quality and one which seeks to reflect the constantly shifting policy and practice environment as well as the work of partnerships as they mature over time with their participants gaining in confidence (or not) in their work.

5 Evolving Partnerships

Following initial interviews with DsPH among others, reported in the previous chapter, a second round of interviews was undertaken with the DsPH in our nine study sites after a lapse of eight to 12 months from the initial interview. Eight DsPH took part in these interviews. At one study site, in the intervening period, the DPH had moved posts and their successor, who had just been appointed, declined to take part on account of an absence of any background knowledge of the LA and PCT.

The main themes of these follow-up interviews were:

- changes in the way the partnership is structured or operates
- progress with LAA targets
- public health milestones or successes achieved
- public health and the financial impact of the recession
- changes in political administration and the potential impact on the public health agenda
- policies or measures that have helped or hindered public health partnerships
- policies or measures that have helped or hindered public health overall.

5.1 Interviewee accounts

5.1.1 Changes in the way the partnership is structured or operates

Re-structuring of how the partnership operates at LSP level and below had been undertaken in a substantial number of the study areas. A number of reasons were advanced for such re-structuring, including: in two authorities the partnership was deemed inadequate by an IDeA review and as a consequence more senior members were appointed to LSP executive boards and more involvement from the third sector was required in one of these authorities. Another reason given for restructuring elsewhere was a perception that the partnership structures had become too complex and needed to be streamlined and made to 'fit' better within the corporate governance structures of the LA. The DPH in this area gave a flavour of the complexity of partnership structures:

'I've got to present something to the Health Theme Group on my...recommendations...and then have some discussions with them about how we structure [them]. And kind of alongside that just to complicate things we've got other structures to...take into account. We've got...that sort of they need to link in somehow, we've got an adult services transformation board. I think all areas go through th[ese] transformation programmes. So they've got...a board with members, and then they've got other groups under that, and then we've also, just to add to the complication even more, we've got a proposal from Adult Services for a whole new joint commissioning structure with another kind of board with

lots of groups under there. So it's all getting a bit like oh my God, you know' (DPH, site 6).

The stated aims of restructuring were to ensure that the right people with commensurate seniority and responsibility were on the right boards to give them more impact (i.e. LSP executive board) across the LA corporate structure. As mentioned, the other aims of restructuring were to streamline the partnership structures and ensure they had a better fit within the LA committee structure overall.

Respondents were asked if any agencies had joined or left the partnership since they were last interviewed. None reported any groups leaving or joining but it was mentioned in some cases that some organisations had become more involved in the partnership, eg the police, the third and business sectors, and, in one local authority, leisure services (following a restructure) had taken on a more prominent role in the partnership.

5.1.2 Progress with LAA targets

DsPH were asked if the public health targets adopted in their respective LAAs remained on-track or not, and/or if there were any matters for concern. Broadly speaking, it was reported that most targets were being met but some areas of concern centred on targets for alcohol reduction and teenage pregnancy. As these respondents explain:

'We're still struggling on the alcohol, on NI 139, which is the alcohol attributable reductions in hospital admissions, is a very challenging thing to achieve. It doesn't mean it's not got the right target because it is the right target. Whether we achieve it or not is another matter. But that doesn't mean it's the wrong target. Just the work we need to do is the right work for the needs of the population' (DPH, site 1).

'We will not hit teenage pregnancy...There's no possibility of our hitting it in the timeframe' (DPH, site 7).

In this situation, the target insisted upon by Government Office was believed to be unrealistic in the time-frame given to achieve the goal. Overall, there had been no changes to agreed LAA targets.

In respect of the monitoring of targets, performance management was being undertaken. However, there was recognition of data not being fully up-to-date and, conversely, how the absence of such data can affect monitoring. In some instances, local initiatives were undertaken to get a more accurate assessment of the situation.

These two DsPH gave examples of performance monitoring and instances of obtaining more timely data:

'I mean certainly [the] public health targets, the way we work it is that they're monitored...and we have a performance team, the head of performance for the PCT's also part of my team. That we've got programme managers in place, and that we've got project plans in place, and we report, do any exception reporting to the corporate directors group

which is the executive group and the board. So that's on a regular basis. So, you know, they're scrutinised on a monthly basis in terms of those targets. So yes and...that information then is also fed into the system for monitoring the LAA performance and the council's corporate plan...performance' (DPH, site 9).

'...we've got, with the health partnership again...regular meetings taking place with performance...teams or facts for performance teams from the local authority and the PCT that are jointly meeting, and they've got that responsibility of chasing up various commissioning managers to get updates, and also there obviously they will be getting the actual formal performance data and feeding that in. So the idea is basically to flag key areas where we're not performing on target and basically get commissioning managers either in physically into the meeting or to produce reports to say what's actually being done to address that poor performance' (DPH, site 6).

The following respondent related the frustration of having to rely on data that were unreliable:

'The problem for me on smoking is it's all synthetic data. I really want to get some survey people in and just do a survey on how many people smoke. Because, you know, I'm relying on synthetic data. You know, I could put a million pounds into helping people give up smoking. I can't actually count and measure. You know, in a year I don't know how people are still smoking. Synthetic data is synthetic data...' (DPH, site 8).

Another respondent described a local initiative in regard to teenage pregnancy to obtain more up to date data:

'[what] we've been doing over the last few months...because...the national figures are way out of date, very late...is...local tracking. We work with the local hospital which does virtually a hundred percent of our maternity care and also about 90-odd per cent of our terminations, so we can actually work with them to look at figures much more recent than the national ones that come out. So clearly we can't make a comparison with other places but at least we can do some internal tracking of what's happened' (DPH, site 4).

5.1.3 Public health milestones/successes achieved since the first interviews

Since the first wave of interviews with DsPH (8 to 12 months earlier) they were asked if any key milestones or successes had been achieved in the intervening period. A number of initiatives were cited which were deemed to have been successful for a variety of reasons. The following quotations give an illustration of the nature and variety of projects:

'...overall then death rate's fallen by 21%, the inequalities gap between England and [the local authority area] has reduced by 25%, deaths from coronary heart disease reduced by 45%, and the inequalities gap has been reduced by 37%, cancer deaths reduced by 24% and the inequalities gap

reduced by 40%, lung cancer reduced by 31% and the inequalities gap reduced by 41%, infant deaths reduced by 42% and are now below the national average. They were quite high above the national average. And then internally we compared the most deprived 20% of the borough with the net [borough] average, and for all deaths under the age of 75 inequalities have reduced by 27%. The deaths from cancer, inequalities have reduced by 81%...And for deaths from heart disease and stroke inequalities reduced by 22%...So, you know, we are actually seeing the impact now, and I think that shows, I mean I think we've been working at this in a partnership way for the past 10 years or so, and I think that steady work has shown the impact' (DPH, site 3).

'[An]...area where we've made really good progress this year...has been in the whole range of tobacco control. And we've sort of start[ed] hitting our targets and sort of doing some pioneering work around that and that again is very much across organisational or [a] partnership...piece of work. So there are a number of strands of partnership work that are sort of going ahead quite well. Sorry to say, we can't yet demonstrate the big outcomes that we'd hope to get from them' (DPH, site 7).

Another DPH described an initiative to improve the health and well-being of young people and the impact it had:

'And it's taken, it's the youth services, it's the sexual health services, it's the drugs workers, all of them, and what we've created is young people's space...and they've all had to work together to put a timetable together, to determine, to listen to what young people want in there and how they want it. It's been unbelievably successful. Connexions, that's partnership. They actually have changed services. And the outcomes are all the services and all the professionals on the ground, without actually looking at hard data, have all said we have seen 13 to 19 vulnerable young people who do not come to our services. They're getting lots more referrals. Connexions say they're getting loads of referrals from it. Youth Service are able to direct some young people into youth services, and it's just we've got it right for a change' (DPH, site 8).

Other initiatives cited included working more closely with the police in relation to advising young women about emergency contraception if they had been arrested for drunken behaviour and had unplanned sex. Initiatives around alcohol reduction, teenage pregnancy and smoking cessation were also cited.

What is interesting about these initiatives is that they largely focused upon the process factors of partnership (i.e. agencies joining together to engage in initiatives) and in a number of cases there was little mention of the actual outcomes achieved. However, it must also be borne in mind that the results of these programmes would take time to filter through and, accordingly, have an impact. Nevertheless, the continuing emphasis on the process and structures of partnerships, combined with there being less emphasis on an

outcomes focused approach, may be of concern particularly given that LAAs and the CAA emphasise such an approach.

5.1.4 Public health and the financial impact of the recession

While the follow-up interviews with the DsPH were being conducted, the country was in the grip of an economic recession. Respondents were therefore asked what impact the recession was having, or might have, on public health financially and if there were any wider repercussions for public health in terms of partner agencies' ability to contribute financially or in kind.

Three themes emerged from these discussions: first, although no cuts were planned in the immediate future, DsPH were concerned about cuts being implemented in the following financial years. A second theme was that, despite this fear, it was believed public health was higher on the political and policy agenda than previously and therefore may prove more resilient to a cost-cutting agenda. Finally, it was believed that LAs have been, and would continue to be, more susceptible to cuts. Indeed, cuts in council spending had been reported by some respondents. However, there were also concerns over future cuts to PCT funding which is where the bulk of funding for public health is located.

The following respondents voiced their concerns over the actual, and potential for future, cuts in funding:

'The local authority is in a very difficult financial position...And that's continued, and with the economic downturn the prospects are that that will get worse. The other thing that's changed is...the NHS having been in a period of plenty, but we know that there's a deficit this year and that the year after next we all just fall off a cliff. So one of the impacts of that is in the strategic plan we've been looking at permanent posts as part of the programme, but we're now being asked to look at short term contracts and third party organisations and those sorts of things. So that's starting to have a big impact. There's a lot of discussion going on about the economic downturn in the partnership' (DPH, site 9).

'I am worried that the £8m we've put into primary preventative public health programmes in the last three years will be scaled back, but I will do my best to make sure that doesn't happen, even if we have to - I mean on the basis of cost effectiveness and population need, we will decide what we need to do the most, but actually care and treatment is often not very cost effective and doesn't have much effect on population health. So we are setting up rationing systems for the coming years that will allow us to make those decisions, unpopular though they will be' (DPH, site 1).

Another respondent noted that the case would have to be made to ensure public health was not seen as an easy option for potential cuts:

'I think it's going to be really tough the decision making that has to be made, and...it doesn't make sense financially in the medium term certainly to cut back on public health, that's absolutely clear, and we need to have a

very strong financial argument for why we need to keep going with the prevention agenda... if we're too short term in our thinking financially and just pour all our money into the acute sector, then we're going to be just storing up even more financial problems for the future. And so what we're trying to do is make sure we've got all those financial arguments. We have got a health economist working with us, and we're just trying to ensure that we make that kind of argument very clear' (DPH, site 3).

Finally, another DPH noted that although public health may not be as susceptible to cuts as previously, there were still concerns for the future:

'...I'm not totally confident because I think the requirements in terms of savings are so great that it's going to be really quite difficult to actually avoid any cuts at all, because I think, at the moment, we're getting quite generous funding and people are saying well look this is one of our real priorities is reducing health inequalities, and we're getting money and we're not having money taken away from us...And I think there is a commitment to maintain that as far as possible, but I have a fear that we're going to get to the situation where everybody's going to feel quite a lot of pain. So I don't think it's going to be...oh well the easiest thing and the first thing to do is to cut public health expenditure. I think that we're out of that game, and I think it will be much lower down the list of cuts, but I have the fear that the cuts are going to be so deep that it's actually going to get to that point' (DPH, site 4).

As noted, respondents also cited that LA cuts were currently occurring, or being planned, and there were concerns over the impact these may have on public health. As this respondent noted:

'I think it's going to be quite difficult to find any significant funding at all within the council coffers for public health while we're in this recession. I think we might be able to still get some public health growth through the NHS funding, but it will be on a much more modest scale than was the case over the past two or three years' (DPH, site 7).

5.1.5 Changes in political administration and the potential impact on the public health agenda

Respondents were asked whether the local elections had resulted in any change in the political administration in their LA and, if so, whether this change would have an impact on public health priorities. Only two of the eight LAs surveyed held local elections in 2009 and only one change of administration occurred. However, it was not thought that the local election results would have any impact on public health priorities.

5.1.6 Policies or measures that have helped or hindered public health partnerships

The DsPH were asked whether there were any particular policies or measures introduced nationally or locally that had had either a positive or negative impact upon public health partnerships in the intervening months

since last being interviewed for the study. The potential impact of the CAA (due to report some months after the interviews had been completed) was frequently cited by respondents as a measure that could aid, or possibly hinder, the development of public health partnerships. The CAA, as noted in an earlier chapter, is a new way of assessing local public services in England. It examines how well councils are working together with other public bodies to meet the needs of the people they serve. The CAA was developed, and is being delivered, jointly by the main public sector inspectorates.

One respondent cited their hopes and fears in regard to the CAA and, in so doing, encapsulated the views of other respondents concerning their hope that the CAA would show partnerships where they could improve but also their fear over what was perceived to be the Audit Commission's over-reliance on inspection reports and potentially over-looking other important data and the impact of other policy measures:

'I mean I think the ongoing LAA/CAA axis, with our statutory involvement and a sense that we're all going to be measured specifically, is very helpful I have to say. That's the biggest one really. Well, hopeful, [but] having had dealings with the Audit Commission over many years, I'm not entirely hopeful because they basically talk the talk and then give you a rating based on absolute outcomes rather than value added. They're telling us it's going to be different with the CAA, I'm not sure I believe that, we'll see. So, but that aside, I am hopeful that the CAA process will help partnership working in public health - it should, it's been designed to' (DPH, site 1).

5.1.7 Policies or measures that have helped or hindered public health overall

In addition to policies or measures that had helped or hindered public health partnerships, respondents were asked if there were any measures that had helped or hindered public health in general, either locally or nationally, since last being interviewed. No main themes emerged – a disparate number of policies or measures were cited, from investment in local tobacco control to investment in vascular risk assessment at a local level.

5.2 Discussion

From these second round interviews with DsPH, it is clear that process and structure continued to play a prominent role in partnerships and their development. Many instances were cited of partnerships being re-structured to give them more impact and also to streamline their operation within the LA as the partnership structures had become too complex. There was also some evidence of a continuing emphasis on the processes of partnerships, rather than the outcomes, being achieved. However, it was found that performance monitoring was routine within the study sites with a variety of policy mechanisms to ensure accountability. Nevertheless, monitoring was compromised by a lack of timely data in some instances and some local initiatives had been undertaken to obtain more timely data.

There was a great deal of concern over the likely impact of the recession and the future of public health funding. Although it was seen as being secure in the short term, there were serious concerns over PCTs' ability to fund public health at current levels in future years. However, DsPH remained optimistic that the political and policy profile of public health remained high on the political agenda so that it would not be as susceptible to cuts as had been the case on past occasions when budgets had been under threat.

There were hopes and fears over the impact of the CAA: hopes that it could aid partnerships in showing their strengths and weaknesses, and fears that the Audit Commission would tend to rely on inspection reports for its assessment to the detriment of other policy measures and initiatives.

6 The Impact of partnerships

The final phase of stage 2 of the study is based upon the selection of four 'tracer issues' in four of the nine locations reported on in the two preceding chapters. Topics were chosen that were of high priority in those areas' LAAs, namely: obesity (site 2), alcohol misuse (site 1), teenage pregnancy (site 4), and smoking cessation (site 3). These public health issues have been identified in order to establish through interviews with frontline staff and focus groups of service users their perceptions of partnership working.

6.1 Interviewee accounts

A total of 32 interviews were conducted with practitioners in the four study areas and four focus groups in three of the study areas were conducted in regard to three of the tracer issues: obesity, alcohol misuse and teenage pregnancy. Practitioners were for the most part frontline staff responsible for delivering service provision in the selected tracer issue areas but there were also some middle managers in the sample.

The aim of this phase of the study was to address a number of key questions in relation to public health partnerships, including:

- what are the benefits of partnership working?
- what are the determinants of successful partnership working?
- what are the benefits of partnerships for service users?
- what are the views of service users towards partnership working?

6.1.1 Benefits of partnership working

There were many benefits to be gained from working in partnership. Chief amongst these was having a co-ordinated approach to the delivery of services, the benefits that networking with partner agencies can bring, and agencies bringing different perspectives to working in partnership. In addition, having shared agendas, resources and promoting shared expertise were also believed to be key benefits of working in partnership which are evidenced throughout this phase of the study.

A co-ordinated approach

A major theme of the benefits of working in partnership was being able to act in a co-ordinated manner with other agencies. It was believed acting in such a manner brought the benefit of each agency's perspective to bear on tackling a facet of a public health issue in accordance with their knowledge and expertise. It could range from one agency tackling the prevention agenda in teenage pregnancy and another agency offering advice and support to would-be teenage mothers. Having a co-ordinated approach was also claimed to be cost efficient and effective. This could be through pooling resources or co-ordinating publicity campaigns to ensure effective and efficient targeting of messages to the intended audience. It was also believed that given the complex and multi-faceted nature of public health issues ('wicked issues' as we have referred to them) no one agency could

tackle these problems alone and therefore a co-ordinated approach was required. The following respondents exemplify these points:

'...I think on an issue like teenage pregnancy you do have to work in partnership because it is such a complex and enormous issue really. To begin to make an impact on teenage pregnancy...you have to start incredibly young, you have to ensure very high quality provision of sexual health services and contraception services...You have to ensure that people are being developed with aspirations and opportunities which involve education and the economic sector. You have to ensure that people are fully understanding of sexual health, which again is something that heavily involves the education sector. So it is an issue, it's one of those issues that effectively cannot be tackled by any single organisation really; if you are to make any kind of progress it does have to...bring in a very wide range of individuals and organisations' (Deputy DPH, site 4).

'...I could be spending a lot of money on making sure that GPs are identifying alcohol misuse and referring appropriately, but then if...we're granting licences to every single place that wants to open up a new bar and, you know, just allowing people to get increasingly drunk in the city centre, it's almost defying the point of it really. So I think working together can give a better overall approach to alcohol, because we've all got the same sort of aim, so I think that's really positive' (Public Health Consultant, site 1).

However, the main benefit of a co-ordinated approach was seen as offering a more tailored and seamless service for service users themselves. With such a co-ordinated approach between agencies in place, service users would have more integrated packages of care and provision and where one agency could not offer one aspect of provision, users could be referred to a more appropriate agency (the experiences of users is discussed later). These pathways of care and provision were seen as one of the major benefits of working in partnership. It was also believed that those in hard to reach groups would benefit by perhaps accessing one service and then being encouraged and signposted to use other services. This signposting argument is illustrated by a smoking cessation advisor:

'So in fact what I'm offering is a stop smoking service, but what I'm also offering is why don't you join this health training programme, why don't you go on this walk and ...get the health check. So even though that takes me a few seconds, I'm throwing them in, and a lot of the time they'll go yeah, you know what I am interested in that, shall we fax off a referral. And it's all the little things like that, having the knowledge like that, and they do it for us as well, so it works both ways, and it's giving a better health outcome for the residents' (site 3).

It was believed a co-ordinated approach also gave the service user more choice in the services they could access in terms of what was most appropriate to their needs. Also, given that a user may have a number of health and other related issues to deal with, the multi-agency approach was essential in addressing these. One respondent gives an example of this:

'The benefit for them is that they do get a more... [seamless] service; they're not passed from pillar to post. They have an identified worker that can sort of vouch or say I work with this health visitor, she's really good, and it's a bit of reassurance for the young person, so they're more likely to engage with another service because they've got a contact point or a worker or a bit of encouragement to go. And I think they're more likely to engage and get a better service and get more access for the things that are out there. So they'll be less isolated and their children would be less isolated and more willing to progress on to different things, such as maybe education ...as a result of that. And I think it opens a lot of doors for them as well if they can see what help's out there whether it's a health issue or a housing issue or a confidence issue because ...if they have a positive experience with one agency they're more likely to go on and work with another' (Young Parents Personal Adviser, site 4).

Networking

In an age of interconnectivity it perhaps not surprising that respondents believed that one of the key benefits and successful determinants of partnership working was networking. Networking could range from informal or formal partnerships with agencies to arranging training and meetings together to discuss policy and strategy. It was believed networking could, by its very nature, lead to further beneficial partnerships being forged. Networking also allowed agencies to see where their respective agendas and priorities aligned and how they could aid each other and, more importantly, service users. Through networking service users could be referred to the most appropriate agency. Furthermore, networking enabled the profile of agencies to be raised, not only among professionals but also among service users. A further benefit was that through regular contact professionals were kept up-to-date with the latest policy developments locally and nationally. A Health Improvement Co-ordinator illustrates some of the benefits of networking:

'...half [of] my role is putting people together, people who need to meet each other, so it may even be my role would just be introducing one partner to another partner in a particular project. So network[ing] is really important because you get to have a bit of continuity with what you're trying to [do], and there's a lot of the left hand not knowing what the right hand is doing, and so it becomes streamlined, it makes it more efficient and more effective, more value of money, better value for money' (site 2).

Different agency perspectives

Having different agency perspectives co-existing in a partnership was seen as very beneficial. Having agencies give their particular viewpoint on a policy problem or issue was seen as important because the issue or problem was then viewed from every angle and a more rounded and holistic approach was given to resolving issues and presenting innovative solutions. Furthermore, other perspectives challenged the pre-conceived views of each agency which was seen as helpful. The perspectives of other agencies could also change the behaviour of how an agency operated in relation to policy

formulation or implementation. This could be, for example, a slight change in operational procedure prompted by the suggestion of a partner. A Specialist Midwife in Teenage Pregnancy echoes the view of many respondents:

'So I do think that other agencies pick up on different elements...because they're working with them [service users] perhaps in a different way to how maybe I am, you know, they see certain different things that...obviously are very important really and can have a very dramatic effect on the outcomes...for that young person' (site 4).

Shared expertise and resources

A claimed benefit of partnership working was the ability to draw on each agency's expertise and skills. It was believed that this brought major benefits not only to the agencies themselves, by expanding their own understanding and skills, but also to service users by there being a range of professionals to draw upon for support. These respondents illustrate these views:

'...we have a programme of sex education that we deliver in Year 9 in our secondary schools...which is a multi-agency team, so it has strengths of different professionals. So those young people are benefiting from a very broad range of professionals really. The skills of youth workers who can communicate better than perhaps health professionals can. But equally we've got health professionals working in partnership as well so that if any of the questions that come up from the sessions are health related we've got the appropriate people then that can answer those questions. But equally we've got the skills of youth workers who are able to tease out issues that young people may want to discuss' (Teenage Pregnancy Co-ordinator, site 4).

'...you can't do it on your own; no one agency could do it on their own. I mean everybody specialises in their own skills and if you think that you're the one agency that's got all the skills you'll fail because you haven't, you know, none of us have. With working in partnership the families just get every bit of information and service support, because everybody specialises in their own areas...' (Children's Centre Co-ordinator, site 4).

Sharing resources was seen as beneficial by respondents and could range from the free use of a hall for an event, producing information leaflets jointly, to shared training events.

6.1.2 Determinants of successful partnership working

A number of issues can determine whether a partnership is successful or not. Some of these may be under the partnership's control (i.e. how well they share information), and some may not (i.e. organisational change imposed from above and resulting in the breaking up of networks). This section focuses upon what were deemed by respondents as the key factors which could aid or hamper successful partnership working.

Sharing information

A major theme was that despite the predominant view that there was good sharing of information by partners, a significant minority believed that information sharing was either a mixed picture at best or poor at worst. For those who cited good information sharing between agencies, this assessment was usually predicated on sharing information protocols being in place, and agencies keeping each other up-to-date in regard to policy and practice issues. Regular meetings, networking and shared training arrangements also facilitated the sharing of information in addition to the use of dedicated email groups. These respondents echo some of these themes in relation to having information sharing protocols in place and good information sharing between agencies:

'Every one of our clients when we first work with them has filled in a shared information consent form, which then is produced if requested by another service. For an instance and scenario, perhaps one of the agencies that, let's say Jobcentre Plus, we are required at times to obviously, you know, send a fax over and show them the shared information consent because, you know, we're ringing up about young people's benefits, it could be anything...' (Young Persons Personal Advisor, site 4)

'We just have updates, sometimes we have meetings, and they [other agencies] come and join us on our meetings and, you know, always getting updated as well... [and] mainly communicating by emails...' (Stop Smoking Advisor, site 3).

For those who believed information sharing was mixed or poor there were a number of reasons for this: lack of information sharing protocols in place; confusion over what information can or cannot be shared, particularly around service users; and issues of data protection. In addition, and more generally, poor communication between agencies was cited as a reason. These respondents illustrate many of these themes:

'...I think what happens is that a lot of clinicians on the ground get very confused between issues of confidentiality and information sharing, and I think that that can be a real barrier sometimes. I think that we are pushed and pulled in so many directions. We're often criticised, for example, when there are inquiries like serious case reviews or anything, for not necessarily being proactive in sharing information. And I think sometimes that two-way street simply doesn't happen because people, workers on the ground are not clear about what their issues around confidentiality and consent and data protection are. I think it's a very, very complex subject really I think' (Dual Diagnosis Clinical Director, site 1).

'...around physical activity there apparently is supposed to be a website where everything is on there and everybody can find out what's available but I don't think, I mean it's not exactly well-known if it does exist and I don't think our stuff's on there and I've no idea who runs it. So that kind of thing whereby, you know if the PCT or the partnerships could engage with all the community groups to actually say right we're going to promote everything that everybody is doing...' (Environmental Charity Manager, site 2).

'...I think probably that we're not always clear sort of what's going on with the City Council and...Probation and Social Services and so on, and who to share what information with' (Clinical Lead, site 1).

How important is goodwill in the successful functioning of partnerships?

A near universal consensus was that goodwill, as mentioned in Chapter 4, was 'the glue' that kept partnerships together and functioning effectively. The importance of personal rapport and friendship between partners was echoed time and again in interviews. Respondents cited goodwill, trust, and a passion shared in achieving better public health outcomes as the principal features in cementing and driving partnerships forward. A Specialist Public Health Nurse explains what goodwill means in practice:

'I'd say that relationships are key because if you get somebody that you have difficulty having a relationship with in a partnership agency then it's...going to be very difficult. And I think forging relationships with the other agencies was key, and the staff on the ground, the actual smoking advisers, their relationships with other agencies is key... Because we have got good relationships with other agencies here ...and I do know that if I phoned up today on behalf of the smoking service, if I phoned up say the substance misuse or sexual health and said look, you know, there's this young person coming down tonight or whatever, you know, they would wait for them, they would go the extra mile for them, as would the smoking service' (site 3).

Two respondents outlined why personalities can be key in partnerships:

'I think government fails to recognise that partnerships are made up of people, and not positions. Not sort of appointments, they're made up of people. If people don't get on, partnerships will fail. And people get on when they get benefit out of something' (Joint Consultant in Public Health, site 2).

'...for me the issue with partnerships, or any partnership working has to be that they have to be natural or not forced because everybody has their own agenda otherwise. If people have a chance to work together and trust each other and build good quality working relationships based on respect, [then] working relationships work really, really, well' (Raising Aspirations Co-ordinator, site 4).

In addition to goodwill, the role of local champions to drive agendas and partnerships forward were also seen as very important in the multi-agency framework.

The importance of 'local champions'

Local champions – those individuals with the drive, passion and commitment to move the agenda on – were regarded as very important in partnership working. They were the people who develop networks, spread good practice, and help co-ordinate policy and practice in a partnership. Having good policy procedures was not deemed as sufficient or even adequate without there being the people with the drive and commitment to

make policy commitments a reality within the partnership. This respondent explains the importance of a local champion in the context of what happens when they leave:

'...certainly we've struggled for a long time now having to champion teenage pregnancy to be fair, and we...were successful in finding somebody. He was really taking it, you know, we were making real good progress...because he was really sort of pushing all that work sort of forward. So we've had to sort of revisit that, again, and it lost its momentum for a while I think, as like new things do when new people take over who perhaps don't always have that as their main interest if you like' (Specialist Midwife in Teenage Pregnancy, site 4).

Organisational change and the effect on partnerships

Views were split on the effect of organisational change on partnerships. First, there were those who had no opinion or did not think it was an issue either because they were not affected by PCT reorganisation, for example, or because they worked in the community or voluntary sector or at a level where it would not impact their role in the partnership. Second, were those who had been affected by organisational change, either within their own or partner organisations, who believed it did have an adverse impact on partnership working. The main reasons cited for organisational change having an impact on partnerships was the loss of key personnel and the breaking up of partnership networks, and the loss of the 'corporate memory' of an organisation as a result of a merger or re-organisation. The following respondents elaborate on these themes:

'...the memory of an organisation is invested in the people that work in it. If you constantly change the organisation and the people, the organisation...will never have a memory, no matter how well you file the paper, because people...think differently, so they won't file things in the same places' (Joint Consultant in Public Health, site 2).

'Recently there have been some mergers of things and it stops things for a while because everybody is trying to figure out where they stand, where they are...and...you have to build up new links and new contacts, so any mergers and moves does cause a disruption, it's bound to, and they do' (Area Manager, Probation Service, site 1).

Could public health aims and objectives be delivered without working in partnership?

We asked if public health aims and objectives could be achieved in the absence of partnership. Not unexpectedly, a resounding 'no' was the near unanimous response. Most respondents felt that because of the complexity of issues such as alcohol reduction, teenage pregnancy, tackling obesity and smoking cessation they simply could not be tackled by one agency alone. As noted earlier, it was believed that a co-ordinated approach based on the utilisation of different skill sets was required to tackle these issues. In addition, the sharing of resources and expertise also meant that more help and support could be provided to local populations than would be possible in

respect of organisations working by themselves in silos and, most likely in the process, duplicating effort. These respondents highlight some of the reasons why a partnership approach is required:

'...I need to draw in other experts and the other agencies, and I just know that...my service couldn't meet a young person's needs alone because they're just too complex and too broad and that you do need to draw in upon your agencies...' (Young Parents Personal Adviser, site 4).

A Lead Clinician Team Leader describes the impact on their service without working in partnership:

'I wouldn't regard it as a service without it [partnership working] insofar as I would be leading a service which would only be providing a service to probably 40% if that, of those who come in my door. So there are loads and loads of people who are coming onto the wards and who come into A&E and who come into clinics who would end up either not getting any service at all or getting the wrong service without the partnership' (site 1).

Although thus far we have documented the benefits and the determinants of successful partnership working, this is not to say that partnership working does not have its barriers or problems. It is to these issues we now turn.

6.1.3 Barriers to partnership working

Major themes that emerged in relation to barriers to partnership working were the different priorities of other agencies, partners not being aware of their respective roles and responsibilities, and duplication of provision.

Different priorities of other agencies

An agency's statutory priorities, an agency not seeming to share targets and priorities with other organisations tackling a particular public health problem, or an agency being inward-looking and only engaging with their own priorities were seen as some of the reasons for organisations which may be expected to be, but were not, fully engaged in partnerships. These respondents exemplify some of the difficulties of engaging with other agencies:

'...the other services actually considered that smoking was kind of low on the priority. That a bigger priority would be sexual health or substance misuse and then smoking came last, and part of my role was saying to services actually no, you know, smoking kills, do you know what I mean, and quoting the document Smoking Kills and other documents and saying actually, you know, it is just as important and if somebody is smoking cannabis and using tobacco, yeah they need substance misuse but they also need follow-ups in the smoking cessation service as well because they're smoking tobacco. And if they work jointly then that works, that's fine. But I think, yeah, I do think that maybe other services didn't understand it, but also it wasn't a priority for other services. And also, for other services, like say a GP practice, young people aren't necessarily the priority...' (Specialist Public Health Nurse, site 3).

A Teenage Pregnancy Co-ordinator notes how teenage pregnancy is not even a priority within their own organisation:

'...one agency cannot deal with all of the aspects of teenage pregnancy because it's a very broad agenda, and I think that that's possibly why it's never been seen as much of a priority within health. Because it's quite easy to put money into knee operations or something and see a positive outcome immediately as a result of that. Whereas with teenage pregnancy it's often very difficult to determine which aspect of the work you've done has been the cause if you like. It isn't really any one aspect; it's a combination of having all of those things in place' (site 4).

This joint consultant in public health discusses the difficulties with working in partnership with the police:

'Working with the police is quite difficult. They're very command and control, and they don't do the compromise win-win very well. They say they do, they don't. The reality on the ground is they don't. And that might just be down to the personalities of the people. The type of people that go into the police are actually not the type of people that would work in a win-win situation or work for a compromise' (site 2).

A Deputy DPH with a responsibility for teenage pregnancy discusses the problems of a target culture in which agencies and directorates become focused on their own priorities to the detriment of a partnership's shared agenda:

'It's the performance management culture where instead of these agendas being seen as a common agenda for a wide range of organisations and departments etc, it becomes the area that one particular service or one particular directorate is assessed on, and everyone else then sort of thinks to themselves well it's not our problem because we're not being performance managed on it. And I think that kind of culture becomes a major barrier to make it, [partnership working] to driving the kind of changes that are needed' (site 4).

The Director of an alcohol charity discusses the disengagement of social services with the alcohol agenda in their locality:

'...in Social Services it's indolence. It's not a priority. It's just pure and simple indolence, and it's not priority. Interestingly, different agendas bring the alcohol issue to the fore, particularly domestic violence and abuse of children, but otherwise alcohol's not an issue, you know' (site 1).

Finally, this director of strategy and commissioning for an alcohol partnership discusses how the partnership raised alcohol up every organisation's agenda:

'...I think one of the things that we did...we managed to say to the partners look for all of you alcohol is your third or fourth priority, which means it's not a priority for anybody, we need to make it a priority, and we'll make it a priority through the partnership, and that's when we developed the strategy and I think we've had a good response to that...So I think that's the key

thing the partnership's been able to do is to lift the alcohol up, and I think it has become partners' priorities because of that. The PCT made it one of their world class commissioning priorities. The city council made alcohol a priority, and so did the Probation Service. So I think by making that strategy and getting people to commit to doing certain things it's had the effect that has brought that up as a priority within the organisations as well' (site 1).

Are all partners aware of their roles and responsibilities?

It could be said that there was a response of 'maybe' in regard to whether partners were aware of their respective roles and responsibilities within partnerships. Although some respondents believed that partners were fully aware of their roles and responsibilities a more common theme was that they were either unaware, or only partially aware, of them. There were a number of reasons for this and no themes predominated. These respondents give instances across the spectrum of partners' awareness of their roles and responsibilities:

'...we do a lot with children services, then of course as you know where there are care plans then it's quite specific and written and black and white as to whose role and what piece of work that agency's doing; perhaps not so much with the ones that aren't working with children services. But I think because of service level agreements within all those agencies, say we have one with Jobcentre Plus, they're well aware of their roles and responsibilities, and we're aware of ours...' (Teen Parents Personal Advisor, site 1).

'It's a work in progress. We are getting there, yeah. We've been doing a lot of work on alcohol in the last little while and, yeah, we are getting there but we're not quite there yet, no' (Clinical Lead, site 1).

'...I think the most practical [barrier is] just trying to find the time to...create the meetings, time to move forward the actions from meeting to meeting, sometimes...it can be a little bit...some groups end up doing more of the work than others, so there's not such a fair distribution. Sometimes there's a challenge that its kind of whose responsibility is it to kind of carry forward the project as whole...' (Public Health Nutritionist, site 2).

Duplication of services

One of the claims made for partnerships is that they can help avoid duplication and are a useful tool for mapping provision in an area. Respondents were asked how far duplication of services was an issue in their locality and whether it was a good or a bad thing. The consensus view was that there was no, or very little, duplication of services and what there was not a bad thing. A Joint Consultant in Public Health highlights how partnerships help to avoid duplication:

'I think partnership work is really helpful in avoiding duplication. We've just had a discussion...about this lifestyle proposal, and part of it is a telephone based service, and a partner from Children and Youth Services was there because he was very interested in the kind of linkages across children's

families and the wider adults agenda, and we now know we need to think very carefully about how that links with an existing families information service and, you know, we hadn't directly made the connection but now it's yes actually, oh yes. So I think it can really help in making sure we're not duplicating and we're not reinventing wheels and we're building from the good stuff that's already happening...locally...' (site 2).

Another respondent highlights no duplication of their work in regard to smoking cessation:

'...because we all have our separate areas and we know which area everything needs to be referred to, so therefore duplicates should not occur' (Health Protection Advisor, site 3).

This Dual Diagnosis Clinical Director acknowledges that although there is some duplication of services, it is not necessarily a bad thing:

'...I think in substance misuse and certainly in dual diagnosis, the clients are so chaotic that to some degree that duplication, whilst it seems as though it has been rather organic and unplanned in its growth, that actually does provide a very important service, and that is it creates such a good spread of coverage that people do access services, and there's always the risk that if you take some of the elements out of that good spread that then you will lose some people, and I don't think there's a full appreciation of that sometimes' (site 1).

Partnerships and LAAs

Respondents were asked to what extent the targets set out in their LAA impacted upon their own organisation and the partnership as a whole. The consensus view was that respondents acknowledged that their own targets contributed to the greater whole of the LAA target. Though conscious of the LAA target, organisations were, perhaps understandably, more focused on their own target as opposed to the LAA target as a whole. However, awareness of the LAA was present. Although not as predominant, the view was also expressed that the LAA targets set by the LA were unattainable and unrealistic. These respondents give their views on the extent to which the LAA targets loom large or otherwise in their organisation:

'Yeah, we do take it seriously so yes therefore we do feel pressure. And I know the advisers do feel pressure if a young person fails to quit. However, although our quit rates are really low...our cut down rates amongst young people are really high. So that does release some pressure because we know that they at least [they've] cut down and also that they've taken on the knowledge about the smoking related diseases and stuff like that. So, yes, we do feel pressure...' (Tobacco Control Commissioner, site 3).

'We're acutely aware of the targets for teen pregnancy, and obviously we're acutely aware when they're not being met locally' (Teen Parent Personal Advisor, site 4).

'They loom large in a sense of being a significant target to help work towards and me as a kind of passionate person in and around my subject I

want to do all I can to help achieve where we are to get with them. They loom large as well because they're very, it's a figure that's very hard to affect. So, as a target, as a number, it is very hard to change just through the work I do, it can become somewhat kind of psychological demoralising, just to see a figure and think how the heck am I going to affect this' (Public Health Nutritionist, site 2).

'You can feel the pressure in the background. I mean take crime and disorder, for example. You know, there is an agreement that alcohol misuse will be addressed from a crime and disorder perspective' (Lead Clinician Team Leader, site 1).

As mentioned, some respondents felt that the LAA targets were unrealistic and unattainable:

'I think because people have got different agendas. I think having the shared target is really helpful. I think unfortunately the target we have around alcohol is going to be impossible and it's not a good indicator, and so I think people just feel a bit disheartened from the start, because already provisional figures are showing we've already gone up 7% this year. Which...the rest of the country have as well, but I have lots of concerns around the indicator that we're being performance managed on. So I am talking regularly to the Department of Health around this, but I think it's fair enough having a shared target, but I'm slightly worried that because the target is virtually impossible that everyone just thinks well we can't do that one so we'll give up type of thing' (Public Health Consultant, site 1).

I think that people who are setting the targets need to be more on the ground, more on the day-to-day running of the service because they set these targets and they've really got no idea how we're going to reach them. We do. But sometimes they're just unreachable if you know what I mean because people are too far out of the loop (Service Manager, site 3).

6.1.4 Partnerships and service users: what are the benefits for service users?

As noted earlier, one of the main benefits of partnership working is through having a co-ordinated approach whereby service users can be referred to the most appropriate agency with agencies acting in concert to provide clear referral pathways for users. Respondents were asked about the various advantages of, and difficulties associated with, such an approach and to give examples of how it operated to benefit service users. Given the nature of the four tracer issue study areas (smoking cessation, obesity, teenage pregnancy and alcohol reduction) and the number of agencies involved in the different aspects of these complex public health issues, referral pathways varied considerably. However, some common approaches could be discerned in referral pathways.

For smoking cessation in study site 3, referrals were commonly from GPs, pharmacies and health trainers in the locality and through self-referral by two stop smoking services based in the locality, one community based and one business based.

In relation to study site 1 and alcohol reduction, users could be referred directly from hospital and, if fit, were either recommended to undertake a detoxification programme or given a choice of attending a clinic or receiving information about the dangers of over consumption of alcohol. Users could also self-refer to a number of agencies helping with abstinence or alcohol reduction. There were also other pathways, for example, through the probation service.

In study site 4 and teenage pregnancy, users could be referred from a GP, the education service, teenage pregnancy support youth workers, or from social services, for example, and a number of agencies in the area offered support for teenage mums and would-be teenage mums.

In regard to obesity (site 2), referrals were either through GPs, dieticians, and advertising of various keep fit activities or word of mouth.

In what follows, respondents talk about the referral process and the advantages of working in partnership and how that benefits service users.

A more seamless service

As noted earlier, with agencies working together a co-ordinated pathway could be offered to service users, with users referred to the most appropriate agency at the appropriate time. Respondents give examples how this works in practice:

'I've had a referral this morning for a shared house that a client had given the written consent [that they] can they contact me for the information. So it's easier for her, she just passed on my details and now I can take and do that work with the supported housing, so she's not having to relay all her situation and circumstances yet again. So...I think that's a real positive for any service user is that they're not having to explain everything to a different face' (Young Parents Personal Advisor, site 4).

'...we get people coming through our door who need this service, that service, the other service, let's develop a system so that we can move our client...from our service seamlessly into yours, so there is a continuum of care that can be tracked, that it's very clear who takes responsibility and when responsibility is handed over and that that is clear and it is understood what information passes between people and why...So that's the big advantage, it's efficient and it's efficacious...So the important thing is to make sure that you can move people through quickly and easily. So, you know, with identified pathways... [It's] a bit like going to the optician's, you get your eyes tested, here's your prescription, take it where you want to get your glasses made up. That's the obvious advantage. So what it does mean of course is that there is more money in the system because there is less duplication' (Executive Director, Alcohol Charity, site 1).

'...you've got a...vulnerable young person, that doesn't access any type of service for sexual health, physical activity, all the other things that we're working on in public health, they don't access any services. The only service that they maybe access is youth offending because that's the only one that they have to basically. If you can get people within that agency

working on all these other agendas as well, so offering that young person sexual health advice, condoms, Chlamydia screening, the opportunity to join in some time of physical activity, some type of team work, something like that, through that one agency you're able to press a lot of buttons for that young person and you're able to offer them a lot more because of the fact that you're in partnership working with other agencies. Now that young person is never in a month of Sundays going to walk into a sexual health clinic, do you know what I mean, but they're accessing that service because they're doing it through the organisation that they do access' (Choices Co-ordinator, site 4).

A smoking cessation advisor notes how working in partnership means being able to tackle a person's health problems which may be multi-faceted:

'...it's no use someone coming to me, giving up smoking and then going, you know, I'm putting all this weight on, I'm sick of it, and you're going oh that's awful that isn't it. Whereas instead I'll say you know what here's the information for the health trainers, they're absolutely brilliant, and [that's] what I'll do...and then...they don't get dumped out of the health and social care chain then. Once they leave [the smoking cessation service] they go and they join another health and social care chain, and they go around like that. And by keeping the client in the system that way with another agency they're less likely to go back to smoking because they're taking a full lifestyle change; not just giving up smoking, they're doing it all in one go. So that works better I've found. I get more people [to] quit that way' (site 3).

The difference partnership working makes to the lives of service users

Respondents were asked to give examples of how working in partnership aided services users. Apart from a more seamless service, and users being signposted to other services they may need, respondents identified a range of reasons to explain how partnerships made the service user experience a better one. Some examples of interviewees' accounts follow.

'...I've had some success [when]...working in partnership [it was]...helping schools achieve healthy school status from a position a few years ago whereby we were sort of meeting government targets, but we were kind of only just meeting, to a point where we have now all our schools engaged on healthy school status; 98% of them are now through as healthy schools. That was only through partnership working between the authority and the schools or individuals from the schools that we...got to that place...' (Public Health Nutritionist, site 2).

'...we do some serious amount of work within the...Schools Sports Partnership, so we do a lot of football based projects down here for them within sort of like the schools' league system. Moving a little bit away from that we do work with some of the more specialised schools like behavioural problem schools as well. But we also run healthy walking schemes, which basically [the] Council hold one every other week, and we hold one in the weeks when they're not holding theirs, so basically there's a healthy walk commencing every week...now' (Manager, Leisure Centre, site 2).

'I think we can offer them a holistic service by being able to share. Because there's sometimes things I wouldn't be able to do alone, and I think having the benefit of like, for example, you know, I work with [another agency] very closely, and we sometimes do a lot of joint visiting between us, so I'll do my bit and...[they] do their bit, and it's all in one visit if you like so...we put in place what we need to, and then obviously the following up and evaluating what we've done, you know, have we achieved what we set out to do, you know, have we got them re-housed, have we got them support, you know, have we sorted the contraception out, you know, they've got a healthy baby, they can access services. And I just think sometimes when you look at the outcomes and you've maybe helped support the partner and everybody else as well with benefits or jobs and things like that, I just think that is really sort of, you feel like you've done a good job if you like working together on something. And I think if you can provide a lot, lot more for them by working together than being there on your own. You know, eventually, I mean you'll probably get to the same outcome eventually possibly, but it can take a lot longer, whereas if you're actually sharing the load along the way with somebody, I think that young person benefits from that' (Specialist Midwife in Teenage Pregnancy, site 4).

A Principal Compliance and Prevention Officer notes how in relation to their stop smoking service going into local businesses has been very effective in addition to co-ordination with other smoking cessation agencies and other partner agencies:

'I think it's been very effective because I think it has sort of provided that range of options to people. Also I think from our point of view, I mean if you look at a person as an individual and sort of draw the circle around them and look at where they're going to visit, where they're going to be, then we've sort of pretty much covered all of those environments, so that provides them with a huge choice really. Also, from our point of view, looking at businesses, we're going into businesses sort of selling the reduction in sickness absence which is a key point for them, you know if people stop smoking, so I think it's pretty much worked well' (site 3).

Although it can be seen that working in partnership can offer a more seamless and holistic service, this is not always the case as respondents did identify, as noted earlier, lack of information sharing protocols which could then entail service users being continually re-assessed due to different assessment procedures being in place.

A not-so-seamless service

Respondents noted that although strides had been made to ensure services were more co-ordinated and seamless for service users, problems remained. Here, respondents give examples of service users who are constantly being re-assessed:

'...hopefully the patient is getting better treatment now and more choice. The only problem with that is, and this is the only guarded thing about partnership work, is that what we don't want to see is people having to jump through too many hoops. So that yeah, I want to self refer, so I go to

my GP. Now my GP hopefully would say go to...our [service]. Now if I saw them and then said actually you look too heavyweight, you need to go to...[another substance misuse service], you could be...passed around from pillar to post a bit, which could be all right, but what we like to do with alcohol services is do assessments. And one of my bug bears is that we assess people to death' (Clinical nurse specialist, site 1).

'...in terms of like referral forms, we're all asking people to fill in the same information time and time and time again, whereas someone's had it to start with so you could pass that information on to your partners to save the paperwork from the participants. I mean by the time you've done like two evaluation forms, two registers, it takes up a lot of your actual face-to-face contact time that you have with people, you think in that time you could have discussed another health message or another one of their concerns or reinforced something, but instead you're filling out [forms], and obviously you know we all need the paperwork, but do we all need our individual paperwork. I think that kind of thing can be frustrating for people I would imagine' (Community Health Development Officer, site 3).

Respondents also gave examples of how different agencies could either be somewhat over-protective in using their own procedures for referral or believing that their referral procedures were of a better standard and therefore refusing to use a common assessment framework. A Clinical Nurse Specialist makes the point:

'But yet there has been always this guard and this competitiveness almost with assessments as in we won't accept your assessment and you won't accept ours. Because there are philosophical problems. If I believe in the 12 step model, it is difficult then accepting someone who comes from a cognitive behavioural kind of model or a social learning model, there are different models in alcohol. Which is good for the patient, but at the same time people get protective about their own clinical practice I think...I think things have got to change...' (site 1).

6.1.5 The views of service users

Focus groups with service users in three of the four tracer issue areas (alcohol misuse, site 1; weight management, site 2; and teenage pregnancy, site 4) were conducted to ascertain their views on issues such as how well they felt services worked together, what improvements were needed, and the impressions of the service provision they had received. It was hoped to conduct a focus group in regard to smoking cessation (site 3) but this did not prove possible (see Chapter 3).

How service users were referred to the service

The majority of users in regard to the weight management service were referred by their GP, or discovered the service through local advertising or word of mouth. For the alcohol misuse group, referrals were either through a GP or from another provider or through self-referral. In regard to the

teenage pregnancy focus group, referrals were generally from other agencies providing support and advice to (or soon to be) teenage parents or through school.

Stories of referral

'Well I was attending another NHS place just around the corner...and they [parents] came home one day and found me completely out of my head, took me there, didn't want to know me, but I knew this place, they brought around here, I saw a counsellor here, and within an hour I was in the hospital and ended up having five days in hospital. But the service I tried to access, the NHS service that I was under, just said we've told you what to do and they wouldn't even let me in the door...basically they said we've taught you how to control your drinking, etc, etc...That's it basically you're on your own' (Male, focus group site 1).

'I saw it in the local paper, and I was having problems anyway with blood pressure and things and I'm overweight. And when I mentioned to my doctor that I was coming, oh he was so pleased, and I really thought well if you'd have mentioned this six months ago, if I'd known about the scheme, I'd have come sooner because both my husband and I have come and we've managed to lose quite a lot of weight. So in a way I was quite disappointed that although it was being funded by our... [local] NHS, my GP never thought to mention it....' (Female, focus group site 2).

'Careers interview from school, and I didn't really go to [current service provider], I didn't really go for a while until about a year later...' (Female, focus group site 4).

Clear referral system to other providers

Focus group respondents were asked if there was clear help and advice for referral to other providers for any other issues they may need help with. Those in the weight management focus group were unclear about what help and advice was available as these respondents illustrate:

'You see this is where we need to...get everything together. Nobody knows what's going on, even the doctors don't refer you unless you ask them or somebody tells you' (Female, focus group site 2).

'What I found a bit, I suppose a bit disappointing, I was referred through my GP. I'm a diabetic so I have an annual check up and my blood pressure was high and I take tablets for cholesterol, so my GP referred me, and my body mass index was very high. And my GP referred me and followed me, I used to go to the nurse but of course I don't know whether it's because when I went for my last annual check up my blood pressure was down, my cholesterol was down etc. I'm now left, I'm now left to get on with it myself. So that's one of the reasons that I've joined [the weight management group] as a premier club member so that I pay every month and I make sure I go. But the follow up I'm a bit disappointed with, but I suppose that's life really' (Female, focus group site 2).

Those in the alcohol focus group tended to be generally very aware of the services in their area and many of them had used a variety of them in the past with mixed views on their effectiveness and the referral process. However, this teenage male was a first-time user of the service and this was his experience:

'Well I went to the GP at various times, because I've been living abroad and I came back and I was in a nervous state, and all the GP would say was you've got to cut your drinking back over a few days, which is really hard to take for someone who's, you know, if you're not being watched so. But I didn't know anywhere to look or anything so I had my dad to thank for researching on the internet and pretty much driving me here in some sort of state, which I don't remember, but as everyone's said it's been quite helpful here. Since then, I just got out of hospital two days ago because of drinking, I was in over the weekend, and the hospital sent me to the place, [NHS provider] that he was talking about, so I'm a bit confused about where I should be going and what, I mean I've only been there a couple of days and they're asking me if I want acupuncture and stuff, but not really, so yeah' (Male, focus group site 1).

Those in the teenage pregnancy focus groups were generally aware of what services were available to them but this respondent echoed the feelings of many that the information needed to be more accessible:

'Yeah, it's almost like if these people who work in these services don't come in, [to the classes they were attending] then we're never going to find out about [them], you know, maybe it's be a bit easier if they just get one of those like folding card things that have some numbers on, you know, get them posted through your doors by the police and on emergency and stuff like that. You know, it's not exactly expensive to make a few of them and give them, is there?' (Male, focus group site 4).

How could services work more effectively together?

Service users had a variety of ideas of how services could work more effectively together and be more co-ordinated, as this male respondent from the weight management focus group notes:

'Now I've been seeing a dietician for about four years and still, you know. Last week he says nothing, sorry there's nothing we can do for you anymore because you've been with us two years and you haven't made an improvement, there's nothing he can do for us. So you go out, so you try other alternatives. I'm trying four different alternatives; I cycle, I go the gym, I go on a special diet, I cut this out, I cut that out, so. And I think there should be, now it's a big problem like cancer, like heart problems, I think there should be a department now that tackles this, do direct action, but not depend on the GPs. Because you go to a GP and you're just a number, you get 15 minutes, he's there to get rid of you as quick as possible, next, because he's got his quota' (Male, focus group site 2).

As this female respondent notes, GPs need to be more proactive:

I think GPs can do a lot more...Most of us know our GPs or have a GP, and I think that if anyone has been there with any problem and they know that you're overweight or they know that you're smoking or whatever it is, then surely they should be trying to help you put that right. And they're the gateway to health, and I'm not sure they see it that way. And maybe it's become a sickness service, but I think that your practice nurses, your nurse practitioners, your GPs are key...' (Female, focus group site 2).

Generally, service users from the weight management focus group believed that services needed to be more joined up and available through their local GP. The alcohol focus group also believed GPs could do more to signpost and help service users, as this respondent makes clear:

'The GPs don't really give you any help because they don't know what they're talking about. You know, you can't just go to a GP and say look I need some help with this problem because they haven't got a clue because they only have a grunt, you know, that they've never had a problem' (Male, focus group site 1).

Of course, providing a joined-up and seamless service relies upon joined-up policy and procedures and strategic partnership working from service providers. Service providers believed there were a number of policy and process issues that needed to be addressed to ensure more effective and joined up service provision.

6.1.6 Policy process issues

Respondents voiced concerns in two areas of the policy process:

- a need for more strategic join up between partners
- a disconnect between the top and bottom tiers of partnerships and within partner agencies.

Lack of strategic join up

Partnerships sometimes suffered from a lack of strategic join up which prevented them from operating at their full potential. This deficit was voiced in a number of areas of partnership working including the different legislative frameworks that agencies work with which made achieving a cohesive and strategic partnership policy framework almost impossible. The legislative frameworks of different agencies may be at cross purposes in some instances. Moreover, the plethora of strategies (i.e. alcohol and teenage pregnancy strategies) needed bringing together into a cohesive whole. The overall impression is that strategic join up is still far from being realised. These respondents give examples of this lack of cohesiveness:

'...what the council have done, slightly bizarrely, again shows probably not high enough level people being involved, is that their corporate directors have set up you know, recently decided they were going to have a meeting about alcohol and they, without telling us, and my Director of Public Health got to hear at the last minute. They were basically, some council person was asked to pull out all the stuff that other people are doing elsewhere and

then look at what we were doing, which felt totally bizarre. We've got all these people working on alcohol already, and suddenly these people who didn't know anything about it suddenly coming along and deciding they're going to make all these suggestions. So I did have an ability to influence some of the content at the last minute, but it felt like they were going you know, my frustration was that none of us who are working all the time know and weren't told about it, weren't involved until suddenly at the last minute someone came along. Oh goodness, it was too late to change much' (Public Health Consultant, site 1).

This Specialist Midwife in Teenage Pregnancy acknowledges the gaps in bringing various public health strands together into a coherent whole:

'I think we can acknowledge that they need to be linked. I think we're actually acknowledging that they're the same, you know, the same themes are coming through, and I think it took us a long time to see that, and I think it's been about oh we do alcohol here, we do this, there and that, and we've not sort of noticed along the way that all of those have an impact on everybody else. So I do think we are getting better but I do think it has been poor in the past, and I think it's been very isolated, you know, we go off and we do the alcohol strategy, we go off and do the teenage pregnancy strategy. Whereas I think now we're getting to realise, as that board, as a group, that it affects, it has an impact on everything, you know, each individual service has got the same issues if you like. You know, the individuals that we're across have got the same issues' (site 4).

As above so below?

There was a general consensus that partnerships tended to operate more effectively bottom-up rather than top-down. There was evidence of some disconnect between the top of some partner organisations and the frontline in these same organisations. These respondents encapsulate these themes:

I've had some experiences where people at a senior level pay lip service to it [partnerships], whereas the people on the ground are very engaged with the concept but at the senior level it's not' (Tobacco Control Commissioner, site 3).

'...my experience is actually that one of the good things about grassroot clinicians and workers is that they naturally form partnerships just by written protocols or service level agreements that are mutually beneficial and are most often very, very client centred. And I think when you start to look at wider partnerships and trying to pin that down on paper, it's very easy to overlook those individual flexible relationships that have existed for a long, long time' (Dual Diagnosis Clinical Director, site 1).

'I think you've got a lack of recognition as well about the work going on at ground level. There's an assumption that because our rates are not coming down fast enough that we're not doing anything about it or we're not doing enough about it. And the reality is we're doing an awful lot about it when they stop and listen to what we're actually doing. And I think at the ground level we really do work extremely well with partnerships because we've got

multi-agency teams doing a whole host of work that, you know, wouldn't be able to function if weren't good at partnership working. But I do think at the top end of the scale the partnerships are not as strong' (Teenage Pregnancy Co-ordinator, site 4).

'...I mean there are some people in organisations that are signed up at the strategic level who simply will not play, and they seem to get away with it, which is beyond my understanding but that's it...there's a lot of tokenism, a lot of tokenism. But the reality is that it's the frontline workers that make a difference, you know...' (Executive Director, Alcohol Charity, site 1).

6.1.7 Capacity, commissioning and competition

Lack of capacity of the voluntary sector

Although not a major theme and not an issue put directly to participants, it was highlighted by DsPH, Directors of Commissioning and other senior managers as an issue in the earlier phases of stage 2 and was highlighted again in this phase. There were concerns over whether the voluntary sector had the necessary capacity to tender for services together with a concern from the voluntary sector over the short time-scales for bidding for contracts. These respondents highlight some of these issues:

'You can sometimes get very short timescales for the pieces of work they're commissioning in order to get a bid in, and actually incredibly short timescales to deliver them in as well, and of course there may be kind of national organisations that will do a piece of, sort of attitude research for you at the drop of a hat, but if you actually want to engage somebody locally to do it, you know, their timescales are absolutely potty and then they do nothing with the information for a year, and you think okay we've just killed ourselves trying to deliver that for you within two months when it could have been done over three or four and then you did nothing with the information for a year - it's hugely frustrating' (Environmental Charity Manager, site 2).

'...to have a thriving local and third sector...we're all committed to that, and it's very frustrating for us to be able to have to give money to the statutory sector or to one of the bigger...and larger third sector organisations...who seem to win most of the money. But when we apply the procurement law it's very difficult not to do that, even though we're sort of rooting mostly on the local bid. You know, in terms of law and the challenge and risk, you're almost now forced to take on the big boys, and we would rather be utilising some of our local providers. And we just reorganised our drug treatment centres, so it's a fundamental whole system change, and it's going to be an enormous amount of procurement and new projects over the next three years, and we've involved our local voluntary sector in that, and we're encouraging them. We've had events with the national providers to introduce them to the local providers so they can work together. But that's all we can do. We can't create a situation where we say we're going to give this to a local provider' (Director of Strategy and Commissioning, Alcohol Partnership, site 1).

Commissioning issues

Another issue, which, again, was not a feature of this phase of the study but was raised by respondents, was the role of commissioners and particularly the quality of services they were commissioning. There was some concern over whether commissioners had a good understanding of the quality of services they were commissioning. Ensuring that the specific outcomes to the organisations being commissioned were clearly understood was highlighted as an issue. These respondents were typical in their concerns on this point:

'...I think that the PCTs understanding of services they commission has got to be given more of a profile. I worry that there are a lot of people who are commissioning services that just simply don't understand the client group that are being commissioned for, or the services that are being delivered, and personally I sit here and struggle on how commissioners can do that because you're essentially commissioning in the dark really' (Dual Diagnosis Clinical Director, site 1).

'...I still think that sometimes where the amounts [of money] are smaller amounts... because if they're commissioning something out and they write an ITT [Invitation to Tender] and it's all very clear and that's fine but I think where [its] small amounts it still would have been more useful for there to be a recommended kind of a template that they're actually being agreed to target so that everybody does know exactly what they have agreed to fund and what outcomes they're expecting...' (Environmental Charity Manager, site 2).

'...I think that the key thing for any service provider, whether it's a statutory or non-statutory service provider, whether it's for profit or not for profit, the key thing is what does your service level agreement say you've got to do, and to me that's a tool that has not been well used. So it suggests to me that the commissioning bodies just need to be very clear what they want and...spell it out' (Executive Director, Alcohol Charity, site 1).

Competition and partnerships

Concerns were raised about the collaborative nature of partnership working, with many of its central features (as we have seen) being based on goodwill and trust, and the active encouragement being given to competition and market-testing among prospective providers. The view expressed was that the competitive nature of agencies competing for funding under the NHS commissioning process risked clashing with the partnership ethos thereby causing tensions within the partnership. There was also some concern over partners 'talking up' how well their service was performing to other partners for fear of being decommissioned. The following respondents illustrate these points:

'...It can affect relationships when...the authority commissions out to an organisation that's already around locally, and another loses out there, that could definitely create a problem' (Public Health Nutritionist, site 2).

'...and I think that's one of the things that we notice in a sense that with one provider we suggested that we, because we're such a small service and we have limited resources, we suggested that actually we could do joint training, and they were very reluctant to do that because basically we were talking about two competitors getting in the same room together. So that was a bit disingenuous in a way. But equally they have to work together as well and they have to form their own partnerships. So I think that can fracture partnerships a little bit' (Dual Diagnosis Clinical Director, site 1).

'I mean there is a problem with people being honest about waiting times. Because the more partners you've got round the table, the same amount of money, and so ...everyone's got to be savvy about saying how well the service is doing. That's one of my bug bears of partnership working is that you hear from clients or you hear from other partners around the table that things aren't going so well at a service, but then when you are around the table everything's very rosy and there's not a problem. And I find that very difficult to deal with because I see why it happens, because obviously you don't want your service to be decommissioned, but it's not necessarily helpful when you hear that oh my waiting time is only three weeks when actually you've just referred someone who know it's about six. And that can be a problem with the partnership working; the more partners the less money' (Clinical Nurse Specialist, site 1).

One respondent voiced concern over each organisation trying to meet their own targets which might lead to introspection:

'Well, I think if you've got, particularly where we're working, each one of our providers has their own target, and it makes for not sort of cross referring to the most appropriate place and things like that. I mean working hard on it but, you know, as I say, I do think it does militate sometimes against cooperation' (Tobacco Control Commissioner, site 3).

6.1.8 Is it all worth it?

Given that partnerships are not cost free and incur resource costs both financial and human and maintain (both capital and human resource costs), respondents were asked whether they felt partnerships could justify these costs in terms of the outcomes gained. The consensus was that partnerships could be justified since the benefits they bestowed far outweighed the costs incurred. However, a minority of respondents were a little more circumspect on the issue.

Of those who gave an unqualified 'yes' to this question there were a myriad of responses as to why. Among these were that partnerships were more cost efficient because of economies of scale (i.e. the costs were shared between partners and the return was greater because of the number of

agencies contributing to the outcome). Less duplication, and more efficient targeting of resources through a co-ordinated approach, was another factor mentioned. There were also the intangible assets such as the costs saved from individuals quitting smoking, drinking or taking part in healthy eating and exercise regimes and the savings in respect of future demand on the NHS and wider society. These respondents highlight some of these themes:

'The answer is yes, because what you don't do necessarily in these cost-benefit analyses is look at the longevity of the savings that you make on that individual by them not being in care and not being in prison, not...[needing]... medical attention and so on and so forth. So I think we have to be really, really careful with some of these projects where they might look that the partnership-working and the human and financial resources that have gone into it look to be huge, that we don't purely do a cost-benefit analysis on what's happening today' (Leisure & Culture Development Manager, site 2).

'Most definitely, in terms of, well, for every two people I see I save a life as they say. The cost of NHS care for the people with the likes of COPD and, you know, the treatment of lung cancer, etc, yeah, [its] a high cost effective way...[for] Health, most definitely' (Health Protection Advisor, site 3).

Of those who were a little more circumspect about the issue of whether partnerships justified their cost, there was the view that until tangible outcomes were proved to exist as a result of the partnership then the jury was still out. Since lots of intangible assets of partnership working could not be factored into a calculation of costs and benefits, it was difficult to give a clear unequivocal judgement. There was also the view that partnerships performed well in some areas but perhaps not so well in others. A Lead Clinician Team Leader states:

'...it's a bit like the old WHO vaccination policy for smallpox some years ago. I remember reading a paper on it and somebody asked a very neat question which was: "Does the smallpox vaccination policy work?" Well, two questions about it. One is if it works, why are we still doing it, and if it doesn't work, why are we still doing it, and I think it's the same with this, because if it still needs holding together, in other words, if somebody wasn't still putting a lot of energy and investment into holding it, why are we still needing to hold it, why hasn't it come together, why is it still continuing to apparently pull in opposite directions. And I think that answers the question because if they're not coming together after the length of time of being together, maybe they're so disparate that they shouldn't be together in that format...' (site 1).

7 Discussion and key themes

For those working on the frontline, partnerships have much to commend themselves. Working in partnership was seen not only as providing a co-ordinated approach to tackling public health issues, it was also viewed as being of major benefit to service users by giving them a more seamless service and acting as a signpost for other services they may need to access. Different agency perspectives, it was believed, could lead to innovative solutions in tackling public health issues. Through utilising the shared knowledge and expertise of partner agencies this meant service users could benefit by having access to a variety of services on a number of levels from access to a youth worker to help with finding a home.

Sharing information and having established information sharing protocols again ensured that service users did not always have to give the same information to all other services with which they came into contact. However, it is clear that this remains work in progress and there are still instances of poor information sharing and lack of sharing protocols between agencies.

It is clear that networking was very important both for those working at the frontline and at a middle management level. Networking brought the prospect of further collaborative work with other agencies and could potentially aid the co-ordinated approach of service delivery by partners being aware of the latest developments in practice nationally and locally. It also gave agencies the opportunity to see where their policies and priorities aligned and shape their policy and practice towards collaborative working accordingly.

Goodwill between agencies was seen very much as the glue that holds partnerships together, particularly on the frontline. It was also the case that 'local champions' played a crucial role in networks acting as conduits for sharing information. However, given the length of time partnerships have been in operation it is perhaps only to be expected that they are now regarded as the natural way of doing things. With policy and procedures firmly embedded perhaps there should not be so much reliance on goodwill in order for them to function.

Organisational change can be very disruptive to partnership networks with partnerships having to be reconstituted because of such disruption. What this says about the destructive and destabilising influence of organisational change on the one hand or the enduring strength of partnerships on the other is open to debate.

Different agency perspectives are an issue and can negate, or limit the potential of, effective partnerships. By this we mean that an agency's own statutory priorities and targets invariably take prominence over their obligations to the partnership. This begs the question of how far joint partnership targets should become more commonplace to encourage and cement the partnership approach instead of targets and priorities for individual organisations which can pull organisations in opposite directions.

It was found that not all partner organisations were aware of their roles and responsibilities within the partnership. Once again this raises questions concerning partnerships' methods of accountability and their effectiveness in addition to the leverage partnerships can exert to hold individual agencies to account.

LAAs were seen to be at the forefront of partner organisations in respect of their targets contributing to the overall LAA target, and concerns were voiced over the unrealistic nature of some of these targets.

As already noted, partnership working did provide examples of offering a more seamless service for service users. However, as has already been pointed out, lack of information sharing protocols, poor communication and agencies insisting upon their own assessment frameworks could mean that users were frequently being re-assessed when using other service providers. Such practices would seem to be an indicator of defective partnership working.

Service users also voiced their concern that GPs, for example, were not acting as a gateway to refer users to services that were available in their particular locality. Users were frustrated by the fact that a range of services could be available in their community of which they had no knowledge. They were obliged to make requests to agency providers to discover such information. Yet, practitioners cited partnership working as the vehicle for providing a seamless service and acting as a signpost to refer users to other services if required. It is clear that service users did not see this happening in practice and the lack of information as to what services were available in their communities was a significant source of frustration. There seems to be a clear gap here between what level of service practitioners think they are providing and the actual experience of service provision by users. Perhaps partner agencies would benefit from making an effort to discover user knowledge of services being offered in their locality with a view, if necessary, to rectifying any knowledge gaps.

It was noted that there was a lack of horizontal and vertical strategic join up in partnerships. Different areas of public health policy were not aligned to provide a cohesive framework (i.e. the teenage pregnancy strategy not being aligned with the alcohol strategy in one of our field sites). There were also concerns over the apparent disconnect between frontline practitioners and senior management. The partnership approach on the frontline appeared to be a more organic and holistic process with partnerships formed clearly and flexibly with the desire to deliver a more co-ordinated approach for service users. This contrasted with senior management approaches where the emphasis was firmly on a target-setting approach to delivery on key themes. The consensus among practitioners was that partnerships which worked effectively were essentially 'bottom up' in origin rather than 'top down', with partnerships forged from the bottom up being based around delivering on the needs of service users and constructed from practical necessity.

Although not directly addressed in the study, respondents voiced concern over the commissioning of services and, in particular, whether commissioners had a good grasp of the capacity of agencies to deliver appropriate services. In addition, respondents believed that commissioners should be more explicit in regard to what targets had to be met in service delivery. With reference to the capacity of agencies to deliver, there were particular concerns expressed over the capacity of the voluntary sector to provide services. It was believed that in some instances the smaller voluntary sector agencies did not have the capacity to deliver services. Concern was also expressed over the competitive element of bidding for commissioned services and how this could fracture the collaborative approach of partnerships and potentially sour relations between agencies.

Finally, there was a strongly held belief that the financial and human resource costs invested in partnership working were more worthwhile in terms of the outcomes gained and that agencies were obliged to work in partnership because no single agency could deliver the range of services or possess all the expertise to deliver on such complex public health issues alone. Despite this, it remained difficult to pinpoint how outcomes had been directly influenced or determined by partnership working reaffirming the view that a great deal of faith in it persists.

Despite respondents' belief that partnership working is the most appropriate mechanism to deliver complex public health goals, issues such as differing priorities among agencies each with its own targets to deliver at the expense and neglect of the partnership, combined with such issues as lack of information sharing and lack of clarity over roles and responsibilities in partnerships, show that tensions and countervailing pressures can work against partnerships. For all the rhetoric surrounding partnerships, and the claims made for them, some fundamental core issues remain to be addressed if partnerships are to function more effectively in the future for the benefit of the populations they are there to serve.

7.1 Messages from the research

With the study focusing on those responsible for shaping and planning public health objectives as well as on frontline practitioners tasked with implementing and delivering these objectives while also obtaining the views of service users in receipt of such services, a number of key themes can be discerned. When partnerships worked well, we saw that they were clear about their objectives, were aware of their roles and responsibilities with clear lines of accountability, and had robust monitoring in place to ensure priorities and targets were being delivered.

At the other extreme, the message from many of our respondents at all levels is that partnerships which are failing to deliver have common elements, namely:

- A lack of good information sharing protocols in place
- Partners not being clear about their roles and responsibilities

- A failure to ensure that targets are shared and owned by the partnership so that agencies do not disengage when their own targets and priorities become pressing
- Targets can induce a silo mentality, hence the need for shared partnership targets
- There is a recognition that LAA targets are important for frontline practitioners and that their own targets contribute to the overall LAA targets; at the same time, there appears to be a lack of ownership of the LAA targets by frontline practitioners with some of the LAA targets being seen by some from director level to frontline practitioners as unattainable
- Frontline practitioners generally held the view that partnerships operate best from the bottom up when they are formed to address the needs of service users in the hope of offering a more co-ordinated service with less duplication and clear pathways for referral; such partnerships were seen as more organic and holistic, relying more on sharing information, good networking and information sharing protocols which were agreed pragmatically and flexibly as the need arose
- There appears to be a disconnect from the top to the bottom in some partnerships where information does not flow easily from the top down and the communication of goals and priorities is not clear or consistent; in addition, a sense of common ownership of targets and priorities is not evident in all cases with clear communication, sharing of information and engagement at all levels of the partnership being regarded as essential pre-requisites of high trust relationships
- It remains the case, from the evidence from our fieldwork, that too much emphasis is placed on policy processes and structures and not enough on outcomes. A more outcomes based approach seems desirable with lessons to be learned from frontline practitioners who may have developed solutions based on particular service users' needs in a holistic and streamlined manner, rather than through complex policy processes which, as we have discussed, can take the focus away from an outcomes based approach.

Although partnership working received positive support in the main from our study sites, digging a little deeper into its processes and structures, as this study has sought to do, reveals a more mixed picture which begins to question the need for some of the existing, and often elaborate, partnership structures. They may endeavour to be all-inclusive but can at the same time become unwieldy and overly complex and cumbersome. Therefore, the need for more loosely based partnerships, as a way of doing business, formed to perform certain functions and tasks and then disbanded when these goals have been accomplished, may merit further consideration. Such an approach is in keeping with a systems thinking framework as outlined in Chapter 2 and we return to some of these issues in the next and final chapter.

8 Conclusions and Recommendations

This has proved a particularly timely study. Partnerships have never been out of vogue – and certainly not in recent times – but the need for them has arguably never been greater. This poses something of a paradox with which our study has been concerned. The silo-based departmental culture and character of our system of government at both national and local levels has triggered a continuing interest in partnerships to overcome the worst effects of working in silos. However, few partnerships have succeeded altogether in overcoming the silo effect or mind set. For the most part, partnerships represent another layer of governance, or ‘add on’, and an uneven one at that in terms of their effectiveness, as our findings show. On the few occasions where partnerships appear to work well, there are many more instances where the costs may outweigh the benefits – at least those that can be ascribed to the partnership arrangements in place which is not an easy calculation to make.

Given the enormity of the fiscal challenges facing all parts of the public sector over the coming years, the strengths and weaknesses of present arrangements will be tested to the limit and, in respect of cross-cutting ‘wicked issues’ of the type to be found in the public health sphere, for the most part they will be found wanting. Indeed, the move by the former government to roll out the Total Place initiative and the present coalition government’s support for it under the banner of place-based budgeting can be interpreted as an admission of this.

Our findings largely support those from the 2009 survey of LAAs and LSPs¹⁰³ which while showing strong support for their achievements also showed significant concerns about progress, the bureaucracy involved, and the risks to delivery. Our interviews have also revealed a number of concerns meriting attention. The findings point to the need for much greater clarity and rigour in the way partnerships are formed, led, and performance managed although given the complex nature of public health problems this is unlikely to be straightforward or even always possible. At the same time, this is not an argument for axiomatically retaining or building on existing partnership structures in respect of LSPs and LAAs although that may be the desired (and right) solution for some areas. Given the systems perspective we have adopted in our study, it suggests the need for a rather different approach to how partnership working is conceived and pursued. We have drawn on the literature which describes wicked problems as being characterised by poor ‘focus’ and limited agreement about what exactly the problem is and by uncertainty and ambiguity about how it might best be tackled. Wicked problems are invariably complex and rather messy, sitting outside single departments or silos and across systems. They are not tame and neither are they complicated. Yet they are precisely the sort of problems which partnerships are set up to confront. Our research suggests that such complex, dynamic and interdependent ‘tangles’, as they have been called, have no correct solutions.¹⁰⁴ At best, as Simon put it in his classic study of administrative

behaviour, it may be a case of 'satisficing' rather than 'optimising', that is, living with the mess and making sense of it.¹⁰⁵ In such a context, most of our current thinking about partnership working falls short of what is required to make effective inroads into a series of wicked issues which are often interconnected, i.e. the issue of obesity, say, may be embedded in the issue of health inequalities; or, as we saw in one of our sites, the issue of teenage pregnancy may be inextricably linked to alcohol misuse. Instead of a continually reflexive and self-examining approach, managers are, or feel, compelled to establish structures and mechanisms based on tools and guidance that risks them becoming deskilled. Yet, 'what may be required are 'clumsy' solutions which avoid a search for perfection and seek to 'craft' a way forward by pragmatic negotiation, bargaining, and a system-wide approach embodying working in partnership with other groups and agencies'.¹⁰⁶ We return to these issues below.

With the arrival of a new government (in May 2010) committed to public sector reform, including the NHS and local government, there are both risks and opportunities when it comes to addressing many of the issues raised by our research. The risks relate primarily to the dislocating effects of yet another 'big bang' structural NHS reorganisation which was announced in the government's white paper published in July 2010.¹⁰⁷ If the changes are implemented as proposed then the current partnership arrangements will be replaced by health and wellbeing boards whose primary aim 'would be to promote integration and partnership working between the NHS, social care, public health and other local services and improve democratic accountability'.¹⁰⁸ Although statutory health and wellbeing boards are the government's preferred solution, if other solutions emerge in the consultation phase, they will be considered. There is something of a paradox here. On the one hand, the government is anxious that localism should prevail with the option that local partners may prefer to design their own arrangements. On the other hand, statutory health and wellbeing boards mandated by central government are the government's preferred solution. How local government may react to having statutory boards imposed on it from the centre is not known but it seems unlikely that such a solution would appeal for a variety of reasons. It also risks squeezing out the very creativity and innovation that locally arrived at partnership arrangements may encourage.

The key conclusions and messages from the research reported above are therefore both timely and relevant given the government's desire to reduce bureaucracy, make partnerships more effective, and see them focus on place-based budgets (the successor to Total Place) that are concerned with cross-cutting health issues.

8.1 Sense-making about partnerships

As our research shows, many of the issues that have exercised partnership working in general over the years appear to apply and remain alive in the context of public health partnerships. This is the case both now and in the future as changes in the NHS and local government, announced by the coalition government, are implemented over the next two years or so. Despite the introduction of various structures and systems (currently LSPs and LAAs but destined to be replaced by new structures over the next few years), these appear to be of secondary importance in determining whether or not partnerships are perceived to be effective. Of greater importance is the existence (or absence) of trust and of relational issues among those engaged in partnerships and trying to make them work. If these are strong and well developed, then the perception at least is that partnerships work better and stand a chance of making real progress. The word 'goodwill' was mentioned several times by many of our interviewees. Some provided examples of where this had occurred. But it seemed a rather fragile basis on which to build and sustain partnerships especially when they were subject to constant policy and organisational churn and buffeting.

Another key theme is that whatever the weaknesses and limitation of partnerships, they are perceived to be essential if public health issues are to be tackled. We were repeatedly told that the complex and multi-faceted nature of such issues makes it inconceivable and impractical for any single agency to assume sole responsibility for making progress. Few of our interviewees offered any suggestions or proposals for new ways of tackling either partnerships or the issues with which they are grappling. And yet, from what we were told by many of those working at the frontline, it does seem as if a loosening up of partnerships locally, to allow and encourage different approaches, may be worth considering and may even be happening in some places. Whether the forthcoming changes in the NHS and local government will encourage or impede such developments is unclear at this time although a centrally imposed partnership structure, noted above, is a distinct possibility.

The government's plans for changes in the organisation of public health entail giving greater responsibility for discharging the public health function to local government and afford an opportunity to look afresh at some of these issues. However, the full extent of the government's intentions will only become clear once the public health white paper is published at the end of November 2010 and the responses to the consultation on the NHS white paper are known. This will set out the scope and purpose of the proposed National Public Health Service which itself raises important governance issues in respect of DsPH who will be jointly accountable to their local authority and to the Secretary of State for Health at the centre. We already know from the NHS white paper that at local level the role of local government in public health will be strengthened as responsibility for the public health function, and its staff, transfer to local authorities. Directors of Public Health will become employees of local government. Such a transfer is, of course, not entirely unprecedented since, until 1974, public

health was largely the responsibility of local government.¹⁰⁹ Nevertheless, how this arrangement will work alongside the accountability upwards to the Department of Health is a puzzle. Moreover, whatever partnerships emerge locally, an important new player will be the proposed GP consortia which will become responsible for commissioning health services for their populations. It is fair to say that, historically, GPs have not been strong advocates for public health or for investing in prevention. Nor have they shown strong commitment to partnership working.

Looking to the future, and in particular at the government's plans for changes in the public health function and what we have said above, it seems certain that partnership working is going to become even more complex and challenging. Two reasons for this merit particular comment and were mentioned by many of our interviewees. First, with an increasing diversity of service providers being encouraged, and with public health interventions with private (for profit and not for profit) companies becoming more active, the composition and nature of partnerships is likely to change and come to resemble public-private rather than public-public partnerships. Examples of these are already evident in the spheres of procurement and capital building projects and in aspects of social care. They remain the exception in regard to public health but the situation is almost certain to change with implications for the issues considered in this research. A particular concern expressed by some of our interviewees related to the tension between working collaboratively in an increasingly competitive environment. Resolving this tension is likely to be one of the major challenges confronting partnerships in future.

Second, as part of the mixed economy of health that is being encouraged, the role of the voluntary, or third, sector is expected to grow with new organisational forms in respect of cooperatives and social enterprises developing rapidly. There is a long tradition of voluntary sector engagement in partnership working but the expectations of this sector, and the heavy demands being placed on it in the planning and delivery of services, have grown enormously. This, as many of our respondents told us, is putting a considerable strain on their slender resources and leadership capacity.

But although partnership working may become more complex and challenging, its design may also become more local and context-specific which, from our research, is a development we consider has many strengths. If only for this reason, therefore, it is not our purpose here to propose new partnership arrangements. Nevertheless, from the findings to emerge from our research, especially those coming from service users and many frontline practitioners, there might be merit in trying to simplify structures and processes so that they are more joined-up and have a clearer focus on achievable outcomes. This may, in turn, enable partnerships to become more flexible and responsive to public health challenges which would seem desirable given the constantly changing nature of these in the light of new policies and structures but also the emergence of new knowledge and evidence about what may be effective.

Such an alternative approach might be based on themed partnerships involving only those stakeholders directly involved with the particular public health issue, or theme, being addressed. They would be tasked with tackling a specific objective and would replace the catch-all, and potentially cumbersome, partnership body made up of all interested parties in an effort to be inclusive. Themed partnerships would need to be clear about their goals and how they would be delivered, by whom, and by when. They would need to include, and also release, stakeholders as and when appropriate according to their particular expertise and the specific contribution they can make to a problem or issue which itself may change over time. The danger with existing partnership arrangements, as many of our respondents told us, lies in them becoming an end in themselves as distinct from being a means to an end. One interpretation of our findings is that they are pointing towards the need for a new and different approach and one that is consistent with a systems thinking perspective which we outlined in Chapter 2.

The central point arising from systems thinking is the need for a different way of conceptualising and doing partnership – one that embraces partnership working but which also advocates the adoption of a rather looser and less structured approach of a variety mentioned earlier. Rather than there being a predetermined aim or purpose, the emphasis might be placed instead on getting started on some joint action without fully agreeing on aims – establishing what Huxham and Vangen¹¹⁰ call a ‘working path’. Partnerships might benefit from becoming more exploratory, tentative and incremental with both pre-set and emergent milestones. Importantly, the structural arrangements should be just sufficient enough to allow adequate exploration of the unknown. As Edmonstone¹¹¹ argues, the approach to managing change in the NHS and elsewhere in the public sector has tended to proceed as if the problems being tackled are tame or critical or even complicated but not complex. But, as we have sought to demonstrate, the problems being confronted in public health are wicked ones which demand a new and different approach to managing change. As a result, this will impact on both the nature and style of the partnerships needed to tackle such problems. In our view, and given what some of our respondents reported in interviews, these need to become less rigid and fixated on process, more open-ended and inclusive of diverse interests, and more focused on achieving ends that are emergent rather than pre-determined. What our research also shows is that for all their positive features, the present arrangement of LSPs and LAAs may not meet with these requirements while spawning a set of elaborate structures and procedures that, certainly in some cases, may not be delivering what is required and may actually be distracting from doing so.

The Total Place pilots (TPPs) were in one respect an acknowledgement, or admission, that existing partnerships are either not up to the job or are underachieving.¹¹² For instance, in some TPPs innovative approaches exploring flexibilities were adopted to support local action to tackle chronic alcohol and drug misuse. Cultural, organisational and capability barriers were far from absent. Rather like the experience of the partnerships

reported in our research, they posed major impediments to progress in many TPPs. At the same time, the desired redesign of services across organisational barriers is unlikely to be achieved through existing arrangements based on LSPs and LAAs. The cultural, structural and financial barriers need to be addressed in new ways so that resources (human and financial) instead of flowing through departmental silos are allocated to problems or challenges affecting whole communities and places. Above all, what the discipline of the Total Place approach demands is a whole systems way of thinking about problem-solving, with key skills in appropriate leadership and partnership in place. In seeking to retain a Total Place approach through what is termed 'place-based budgeting', the coalition government appears to acknowledge its value.

8.2 Implications for partnerships

A number of implications for partnerships and their future flow from our study. These are aimed at NHS policy-makers at all levels, managers and, in some cases, practitioners. We have decided not to target the implications (we have avoided use of the term 'recommendations') at particular groups within the NHS because we believe that all groups should be encouraged to heed the key headline messages since, to a degree, they are all interrelated. The government's proposals for restructuring the NHS and public health, mentioned earlier, present both risks in respect of our study findings but also opportunities to address some of the entrenched problems our research has identified.

Building on the foregoing discussion, key among the implications for policy-makers, managers, practitioners and others are the following headline messages:

- Formal partnerships can be effective in process terms and the success factors are those that have already been documented in the literature. But when it comes to outcomes it may be that more flexible, looser framework structures that can be adapted quickly in the light of review, evaluation and learning are preferable. There is possibly much to learn from the way frontline practitioners organise themselves jointly to make things happen. In addition, making collaboration an integral part of performance management systems for both individuals and departments would give added impetus to partnerships.
- Effective partnerships appear to have more to do with relational factors than structural or systemic ones. Introducing collaborative or integrative leadership development to nurture and develop skills for joined-up working seems essential since such leadership requires the adoption of a different mindset in which the effective functioning of a team or partnership as a whole is the purpose.¹¹³

- There may be lessons for how partnerships need to be formed and function in the context of complex systems and tackling wicked issues. Arguably, prevailing governance requirements in respect of LSPs and LAAs may be disabling given the type of partnerships that may be needed to meet particular public health challenges.
- What happens (or not) at local level is affected in various ways by developments at national level so a lack of joined up working at that level has consequences for efforts locally to join up; this suggests a need for greater, and more coherent, systems alignment both vertically between levels of government and horizontally across agencies at each level.
- Giving permission to public sector professionals and managers to experiment and try out new and different ways of solving problems has merit (precedents for this exist in the experience of HAZs and HLCs where constant adaptation was a feature); evidence for such an approach seems to fit well with the Total Place initiative or whatever may replace it. Such initiatives could help overcome many of the current barriers to effective partnership working with their focus not on organisational silos but on place and whole communities. For example, appointing elected members/non executive directors who sit outside traditional departmental and organisational structures (national or local), oversee pooled budgets, and have a focus on outcomes might be considered.
- Continuous political and organisational churn is not conducive to effective partnership working. It is a fact of life in public services but still carries a high cost in terms of disrupted relationships and lost corporate memory and experience that can facilitate partnerships and which are easily recreated. It may be unrealistic not to expect things to change but the point merits making all the same – minimising as far as possible constant policy and organisational turbulence and churn which risks hampering effective cross-sector working and the development of sustainable relationships based on trust and understanding. The coalition government's proposals for significant change in the NHS and the public health function pose risks in this respect.

Few, if any, of these points are especially novel – most are borne out by other studies of partnerships of various types especially evaluations of HAZs and HLCs. But they bear repeating since if the transformational change of the public sector desired by policy-makers is to succeed then our findings, and the recommendations flowing from them, deserve attention. Some 10 years after the experience of HAZs and HLCs, many of the same issues arising from extensive evaluations of these initiatives remain valid as our research has shown. Like the HAZ research, we have located our research within a systems framework which is especially appropriate in understanding a variety of contemporary public health challenges and how they might best be met. The

importance of such a framework lies in the avoidance of a focus on the component parts. Instead, attention is directed to examining all the underlying components in order to examine the links and interactions between them.¹¹⁴

8.3 Recommendations for research

- Partnership working is destined to become more complex and challenging in future in the light of a greater emphasis on competition and diversity of provision as set out in the government's plans for reforming the NHS and public health. Research will be needed to understand these new partnership forms, which are likely to include social enterprises and private sector partners, and to assess their effectiveness.
- Experiments with different forms of partnership which rely less on formal structures and more on what appears necessary to tackle complex public health challenges should be encouraged and simultaneously evaluated.
- Research is needed to follow up collaborative leadership development initiatives to assess their impact on practice and on the relationships which are developed across agencies working in an area.
- With changes likely in the location and tasks of Directors of Public Health and their teams together with the establishment of a National Public Health Service as a result of the government's NHS reform proposals, it is essential that the evolution and impact of the changes are appropriately evaluated.

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Appendix 1

Partnerships Search strategy and results (January 1997 to June 2008)

Electronic databases

COPAC (Consortium of University Research Libraries Online Catalogue); ASSIA (Applied Social Sciences Index); Social Sciences Citation Index; IBSS (International Bibliography of the Social Sciences); ABI (Abstracted Business Information); Inform; CareData (of the Social Care Institute for Excellence); Cinahl (Cumulative Index to Nursing and Allied Health); Embase; Medline; HMIC (Health Management Information Consortium); Sociological Abstracts; Social Services Abstracts; SIGLE (Grey literature database); CINAHL; Helmis; Kings Fund; IDOX.

Websites

IDeA; SDO; Department of Health; Communities and local government (ODPM); Health Care Commission; NHS; Social Care Institute; NICE; Local Government Association; Kings Fund; Nuffield; Audit Commission; NHS networks; Big Lottery Fund; HSJ; LGC; The Dept for children, schools and families; NHS Confederation; UKPHA; Info4local.gov.uk; Care Services Improvement Partnership; Health Observatories; National Audit Office; Commission for Social Care Inspection; Ofsted; Department for Work & Pensions; Research into Practice; Research into Practice for Adults; Health Services Management Centre in Birmingham; International Journal of Integrated Care; Big Lottery; JRF.

Search Strategies

Assia

(local strategic partnership* or LSP or health action zone* or haz or healthy living centre* or health wellbeing partnership or regeneration partnership or neighbourhood renewal partnership or health improvement partnership or himp or housing health partnership or health care partnership or health social care partnership or wellbeing care partnership or public health partnership or section 31 agreement* or section 31 or health partnership) and (public health or health inequalit* or health improve* or wellbeing or well being or well-being)

Results – 25 references

*** = truncation**

CareData

This database does not recognise combined search terms. Individual terms (i.e. named partnerships) were searched.

Results – 173 references

Cinahl

- 1 local strategic partnership\$.mp.
- 2 lsp.mp.
- 3 health action zone\$.mp.
- 4 health action zone.mp.
- 5 haz.mp.

- 6 healthy living centre\$.mp.
- 7 healthy living centre.mp.
- 8 health wellbeing partnership.mp.
- 9 health wellbeing.mp.

- 10 regeneration partnership\$.mp.
- 11 regeneration partnership.mp.
- 12 neighbourhood renewal partnership\$.mp. [mp=title, subject heading word, abstract, instrumentation]
- 13 neighbourhood renewal partnership.mp. [mp=title, subject heading word, abstract, instrumentation]
- 14 health improvement partnership\$.mp.
- 15 health improvement partnership.mp.
- 16 himp.mp.

- 17 housing health partnership\$.mp.
- 18 health partnership\$.mp.
- 19 exp HOUSING/
- 20 18 and 19
- 21 care partnership\$.mp.

- 22 health.mp. and 21 [mp=title, subject heading word, abstract, instrumentation]
- 23 wellbeing.mp.
- 24 23 and 21
- 25 public health partnership\$.mp.
- 26 section 31 agreement\$.mp.

- 27 section 31.mp.

- 28 health partnership\$.mp.
- 29 1 or 2 or 3 or 4 or 5 or 6 or 7 or 9 or 10 or 14 or 16 or 25 or 27 or 28
- 30 exp Public Health/
- 31 health inequality.mp.
- 32 health inequalities.mp.
- 33 health improve\$.mp.
- 34 wellbeing.mp.
- 35 well being.mp.
- 36 well-being.mp.
- 37 30 or 31 or 32 or 33 or 34 or 35 or 36
- 38 29 and 37

Results – 79 references

\$ = truncation

Embase

- 1 local strategic partnership\$.mp.
- 2 lsp.mp.
- 3 health action zone\$.mp.
- 4 health action zone.mp.
- 5 haz.mp.
- 6 health living centre\$.mp.
- 7 healthy living centre.mp.
- 8 healthy living centres.mp.
- 9 health wellbeing partnership\$.mp.

- 10 health wellbeing.mp.
- 11 regeneration partnership\$.mp.
- 12 regeneration partnership.mp.
- 13 neighbourhood renewal partnership\$.mp.
- 14 neighbourhood renewal partnership.mp.
- 15 health improvement partnership\$.mp.
- 16 health improvement partnership.mp.
- 17 himp.mp.
- 18 housing health partnership\$.mp.
- 19 health partnership\$.mp.
- 20 exp HOUSING/
- 21 19 and 20
- 22 care partnership\$.mp.
- 23 health.mp. and 22 [mp=title, abstract, subject headings, heading
word, drug trade name, original

title, device manufacturer, drug manufacturer name]
- 24 exp WELLBEING/
- 25 24 and 22
- 26 public health partnership\$.mp.
- 27 section 31.mp.
- 28 health partnership\$.mp.
- 29 1 or 2 or 3 or 4 or 5 or 7 or 8 or 10 or 15 or 17 or 19 or 21 or 22 or
23 or 26 or 27 or 28
- 30 exp Public Health/
- 31 health inequalit\$.mp.
- 32 health improve\$.mp.

- 33 exp WELLBEING/
- 34 well being.mp.
- 35 well-being.mp.
- 36 30 or 31 or 32 or 33 or 34 or 35
- 37 29 and 36

Results – 80 references

\$ = truncation

Health Services Management Centre

Health and Social Care Partnership Programme: publications

<http://www.hsmc.bham.ac.uk/programmes/Publications.htm>

Results – 88 references

Health Services Management Centre: current publications

<http://www.hsmc.bham.ac.uk/publications/Current.htm>

Results – 1 reference

International Bibliography of the Social Sciences

- 1 local strategic partnership\$.mp. [mp=abstract, title, subject heading,

geographic heading]

2 lsp.mp. [mp=abstract, title, subject heading, geographic heading]

3 health action zone\$.mp. [mp=abstract, title, subject heading,
geographic heading]

4 haz.mp. [mp=abstract, title, subject heading, geographic heading]

5 healthy living centre\$.mp. [mp=abstract, title, subject heading,
geographic heading]

6 health living centre\$.mp. [mp=abstract, title, subject heading,
geographic heading]

7 health wellbeing partnership\$.mp. [mp=abstract, title, subject heading,
geographic heading]

8 regeneration partnership\$.mp. [mp=abstract, title, subject heading,
geographic heading]

9 regeneration partnership.mp. [mp=abstract, title, subject heading,
geographic heading]

10 neighbourhood renewal partnership\$.mp. [mp=abstract, title, subject
heading, geographic heading]

11 neighbourhood renewal partnership.mp. [mp=abstract, title, subject
heading, geographic heading]

12 health improvement partnership\$.mp. [mp=abstract, title, subject
heading, geographic heading]

13 health improvement partnership.mp. [mp=abstract, title, subject
heading, geographic heading]

14 himp.mp. [mp=abstract, title, subject heading, geographic heading]

15 housing health partnership\$.mp. [mp=abstract, title, subject heading,
geographic heading]

- 16 health partnership\$.mp. [mp=abstract, title, subject heading, geographic heading]
- 17 housing.mp. [mp=abstract, title, subject heading, geographic heading]
- 18 16 and 17
- 19 care partnership\$.mp. [mp=abstract, title, subject heading, geographic heading]
- 20 health.mp. and 19 [mp=abstract, title, subject heading, geographic heading]
- 21 wellbeing.mp. [mp=abstract, title, subject heading, geographic heading]
- 22 21 and 19
- 23 public health partnership\$.mp. [mp=abstract, title, subject heading, geographic heading]
- 24 section 31 agreement\$.mp. [mp=abstract, title, subject heading, geographic heading]
- 25 section 31.mp. [mp=abstract, title, subject heading, geographic heading]
- 26 health partnership\$.mp. [mp=abstract, title, subject heading, geographic heading]
- 27 1 or 2 or 3 or 4 or 5 or 8 or 9 or 10 or 11 or 23 or 25 or 26
- 28 public health.mp. [mp=abstract, title, subject heading, geographic heading]
- 29 health inequal\$.mp. [mp=abstract, title, subject heading, geographic heading]
- 30 health improve\$.mp. [mp=abstract, title, subject heading, geographic heading]

heading]

31 wellbeing.mp. [mp=abstract, title, subject heading, geographic heading]

32 well being.mp. [mp=abstract, title, subject heading, geographic heading]

33 well-being.mp. [mp=abstract, title, subject heading, geographic heading]

34 28 or 29 or 30 or 31 or 32 or 33

35 27 and 34

Results - 21 references

\$ = truncation

Kings Fund

1local ADJ strategic ADJ partnership\$

2LOCAL-STRATEGIC-PARTNERSHIPS#.DE.

3lsp

4health ADJ action ADJ zone\$

5HEALTH-ACTION-ZONES#.DE.

6healthy ADJ living ADJ centre\$

7HEALTHY-LIVING-CENTRES#.DE.

8health ADJ wellbeing ADJ partnershp\$

9health ADJ wellbeing ADJ partnership

- 10 health ADJ wellbeing
- 11 regeneration ADJ partnership\$
- 12 neighbourhood ADJ renewal ADJ partnership\$
- 13 health ADJ improvement ADJ partnership\$
- 14 himp
- 15 HEALTH-IMPROVEMENT-PROGRAMMES#.DE.
- 16 housing ADJ health ADJ partnership\$
- 17 health ADJ partnership
- 18 housing
- 19 HOUSING#.W..DE.
- 20 17 AND 19
- 21 care ADJ partnership\$
- 22 health AND 21
- 23 wellbeing
- 24 23 AND 21
- 25 public ADJ health ADJ partnership
- 26 section ADJ '31'
- 27 health ADJ partnership\$
- 28 PARTNERSHIPS#.W..DE.
- 29 1 OR 2 OR 3 OR 4 OR 5 OR 6 OR 7 OR 10 OR 11 OR 13 OR 14 OR
15 OR 16 OR 17 OR 20

OR 21 OR 22 OR 25 OR 26 OR 27 OR 28

- 30 public ADJ health
- 31 PUBLIC-HEALTH#.DE.
- 32 health ADJ inequalit\$
- 33 HEALTH-INEQUALITIES#.DE.
- 34 health ADJ improve\$
- 35 HEALTH-IMPROVEMENT#.DE.
- 36 Wellbeing
- 37 well ADJ being
- 38 well-being
- 39 30 OR 31 OR 32 OR 33 OR 34 OR 35 OR 36 OR 37
- 40 29 AND 39

Results – 300 references

\$ = truncation

Medline

- 1 local strategic partnership\$.mp.
- 2 lsp.mp.
- 3 health action zone\$.mp.
- 4 haz.mp.
- 5 healthy living centre\$.mp.

- 6 health wellbeing partnership\$.mp.
- 7 regeneration partnership\$.mp.
- 8 neighbourhood renewal partnership\$.mp.
- 9 health improvement partnership\$.mp.
- 10 himp.mp.
- 11 health partnership\$.mp.
- 12 exp Housing/
- 13 11 and 12
- 14 care partnership\$.mp.
- 15 health.mp. and 14 [mp=title, original title, abstract, name of substance word, subject heading word]
- 16 social care partnership\$.mp.
- 17 health.mp. and 16 [mp=title, original title, abstract, name of substance word, subject heading word]
- 18 wellbeing.mp.
- 19 18 and 14
- 20 public health partnership\$.mp.
- 21 section 31 agreement\$.mp.
- 22 section 31.mp.
- 23 health partnership\$.mp.
- 24 1 or 2 or 3 or 4 or 5 or 10 or 13 or 15 or 17 or 20 or 21 or 22 or 23
- 25 exp Public Health/
- 26 health inequality.mp.
- 27 health inequalities.mp.
- 28 health improve\$.mp.

- 29 wellbeing.mp.
30 well being.mp.
31 well-being.mp.
32 25 or 26 or 27 or 28 or 29 or 30 or 31
33 24 and 32

Results – 286 references

\$ = truncation

Social Services Abstracts

(local strategic partnership* or lsp or health action zone* or healthy living centre* or health wellbeing partnership* or wellbeing partnership* or regeneration partnership* or neighbourhood renewal partnership* or health improvement partnership* or housing health partnership* or health partnership* or health care partnership* or care partnership* or wellbeing care partnership* or care partnership* or public health partnership* or section 31 agreement* or section 31 or health partnership*) and (public health or health inequalit* or health improve* or wellbeing or well being or well-being)

Results – 49 references

* = truncation

Sociological Abstracts

(local strategic partnership* or lsp or health action zone* or haz or healthy living centre* or health wellbeing partnership* or regeneration partnership* or neighbourhood renewal partnership* or health improvement partnership* or himp or housing health partnership* or health partnership* or health care partnership* or care partnership* or health social care partnership* or social care partnership* or public health partnership* or section 31 agreements or section 31 or health partnership*) and (public health or health inequalit* or health improve* or wellbeing or well being or well-being)

Results - 29 references

* = truncation

Social Sciences Citation Index

TI=(local strategic partnership* or lsp or health action zone* or haz or healthy living centre* or health wellbeing partnership* or regeneration partnership* or neighbourhood renewal partnership* or health improvement partnership* or himp or housing health partnership* or health care partnership* or health social care partnership* or wellbeing care

partnership* or public health partnership* or section 31 agreement* or
section 31 or health partnership*) and TI=(public health or health
inequalit* or health improve* or wellbeing or well being or well-being)

Results = 157 references

TI = title search

* = truncation

Appendix 2

Topic Guide A – Joint Director of Public Health

About your role

Q: What do you feel your post contributes to partnership working?

Probes: member of the LSP executive group or equivalent, part of each organisation's senior/chief officer teams? Who are they accountable to? Is the post joint funded?

Q: Is there anything about joint posts that you think ought to be changed in order to aid their effectiveness?

The perceived need for partnership

Q: What do you understand by 'public health partnerships' or 'working in partnership for public health'?

Q: Could policy goals and outcomes in public health be achieved without a partnership approach? If not, why?

Potential strengths of partnership working in public health

Q: How well do you feel partnerships for public health are working in your area?

Q: What constitutes a 'successful' or 'effective' partnership working in the context of public health in their area and can they give any examples?

Probes: clear vision, realistic aims and objectives, commitment from senior levels of each partner, high levels of trust, clear lines of accountability, good communication.

Potential barriers to partnership working

Q: Are some partners perhaps more committed than others? *Probe:* different priorities of other agencies (e.g. the need to meet organisational targets and own policy priorities detract from full engagement).

Q: Are all partners aware of their roles and responsibilities?

Q: Do all partner agencies share information as required?

Q: Do all partners recognise the importance of public health and health inequality priorities equally – if not, where are the gaps?

Q: How much is partnership based on 'goodwill' between agencies

Q: How engaged are partner agencies in: Health intelligence, to inform and direct the commissioning of services? Health promotion; Health Needs Assessment; Health Impact assessment?

Q: Do the partnerships policies, processes and structures hinder or help in achieving desired outcomes? For example, do all partners agree on what is given priority (e.g. medical or social focus), and are the policies and targets needed to achieve this outcome focused. Ask for examples.

Determinants for successful partnership working

Q: Which organisations/sectors do you think are crucial in successful partnerships for public health?

Q: Are there any agencies not currently 'on-board' who should be?

Local Area Agreements (LAAs)

Q: Do you feel decisions about the focus of the LAA have been made jointly between partners?

Q: Do you feel arrangements for funding initiatives relating to the LAA adequately reflect the contributions and responsibilities of all partners?

Q: Do you feel that LAAs will have an impact on partnership working on the ground?

Q: To what extent do you accountability for LAAs is jointly shared between partners?

Q: How much input have they had into the LAA and Community Strategy?

Joint commissioning for health

Q: Is there widespread agreement in the locality on the nature of the Joint Strategic Needs Assessment (JSNA)?

- Is there a robust infrastructure in place to develop and prepare the JSNA?
- Does JSNA data provide a full picture of the diverse health and wellbeing needs of the community?
- Are clear and agreed priorities for local action derived from analysis of JSNA data?

Q: Could you describe any factors which, in your view, act as barriers to effective joint commissioning for health and well being in your area?

Impact of partnership working on public health initiatives and public health outcomes

Q: Are there any specific initiatives relating to public health that you feel have been aided by partnership working in your area? If yes, ask for examples.

Q: Overall, do you feel working in partnership is likely to impact on public health outcomes in your area? If yes how and why. If no, what are the barriers?

Q: How can you be sure that outcomes due to partnership and not, for example one agency or national policy or a combination of both?

Q: What (if anything) is needed to ensure better public health outcomes in relation to the partnership?

Q: Do the financial, time and human resource costs of partnership working justify the means in terms of outcomes gained?

Looking to the future

Q: How in 3 to 5 years time would you like to see public health priorities and outcomes develop in your area?

Q: What help and guidance from government would you like to see happen in the next 3 to 5 years?

Topic Guide B – Officers and Councillors

About your role

Q: What do you feel your post/role contributes to partnership working?

The perceived need for partnership

Q: What do you understand by 'public health partnerships' or 'working in partnership for public health'?

Q: Could policy goals and outcomes in public health be achieved without a partnership approach? If not, why?

Potential strengths of partnership working in public health

Q: How well do you feel partnerships for public health are working in your area?

Probe: ask to elaborate about what constitutes 'successful' or 'effective' partnership working in the context of public health in their area and can they give any examples?

Probes: clear vision, realistic aims and objectives, commitment from senior levels of each partner, high levels of trust, clear lines of accountability, good communication.

Potential barriers to partnership working

Q: Are some partners perhaps more committed than others?

Probe: different priorities of other agencies (e.g. the need to meet organisational targets and own policy priorities detract from full engagement).

Q: Are all partners aware of their roles and responsibilities?

Q: Do all partner agencies share information as required: If not, why?

Q: Do all partners recognise the importance of public health and health inequality priorities equally – if not, where are the gaps?

Q: How much is partnership based on 'goodwill' between agencies

Q: Do the partnerships policies, processes and structures hinder or help in achieving desired outcomes? For example, do all partners agree on what is given priority (e.g. medical or social focus), and are the policies and targets needed to achieve this outcome focused. Ask for examples

Determinants for successful partnership working

Q: Which organizations/sectors do you think are crucial in successful partnerships for public health?

Q: Are there any agencies not currently 'on-board' who should be?

Local Area Agreements (LAAs)

Q: Do you feel decisions about the focus of the LAA have been made jointly between partners?

Q: Do you feel arrangements for funding initiatives relating to the LAA adequately reflect the contributions and responsibilities of all partners?

Q: Do you feel that LAAs will have an impact on partnership working on the ground?

Jointly appointed posts

Q: Are there any jointly appointed posts relating to public health in your area?

If yes

Q: What do these posts contribute to partnership working, what (if any) are the difficulties with jointly appointed posts?

If no

Q: Why do you think your area has decided not to make joint appointments?

Joint commissioning for health

Q: How well developed are the arrangements for joint commissioning in your area?

Probe: arrangements for Joint Strategic Needs Assessment

Impact of partnership working on public health initiatives and public health outcomes

Q: Are there any specific initiatives relating to public health that you feel have been aided by partnership working in your area? If yes, ask for examples.

Q: Overall, do you feel working in partnership is likely to impact on public health outcomes in your area? If yes how and why. If no, what are the barriers?

Q: How can you be sure that outcomes due to partnership and not, for example one agency or national policy or a combination of both?

Q: What (if anything) is needed to ensure better public health outcomes in relation to the partnership?

Q: Do the financial, time and human resource costs of partnership working justify the means in terms of outcomes gained?

Looking to the future

Q: How in 3 to 5 years time would you like to see public health priorities and outcomes develop in your area?

Q: What help and guidance from government would you like to see happen in the next 3 to 5 years?

Topic Guide C – Follow-Up Interviews with Directors of Public Health

Partnership Working

Q: Have there being any changes to the way the partnership is structured or operates?

Probe: have any new agencies joined or left the partnership in the last year?

Probe: reasons for joining or leaving

Q: Have there been any re-organisations of partner agencies within the statutory, private and third sectors in the last year? If so, how has this affected the partnership?

Probe: changes in personnel and having to form new networks potentially de-stabilising the partnership? Or, conversely, strengthening the partnership?

Q: Could you give examples of any 'successes' in the last twelve months in relation to public health outcomes or milestones being met?

Probe: how, if at all, did the partnership aid in these successes and milestones being reached?

Local Area Agreements (LAAs)

Q: Have there been any significant changes to the agreed LAA targets in the last year?

Probe: if yes, why have the changes occurred?

Q: Are the LAA targets still on track?

Probe: if yes or no, are there any specific reasons for this?

Probe: are the monitoring arrangements robust enough to give 'early warning' signs of any slippage against targets? If not, what is being done to address this?

Q: Has the financial settlement of the Local Authority or PCT from government meant any public health programmes or any targets having to be scaled back? (For instance, through a lower Standard Spending Assessment for the local authority than anticipated).

Q: Are you concerned, given the economic downturn, that public health programmes may be the first to be cut or scaled back given that they may be seen in some quarters as not a core or statutory service?

Q: Have any partners reduced/increased their financial contribution to the partnership in the last twelve months?

Probe: if yes, what are the reasons for this and how has this: a) affected relations in the partnership, and b) what impact has this had on public health programmes and priorities?

Q: Do you believe that the forthcoming/recent local elections, may/have changed the public health priorities? Has public health been given more/less emphasis politically?

Probe: if yes, what are the reasons for this? If not, why not?

Q: Are there any particular policies or measures in the last year, either locally or nationally, that have helped or hindered public health partnership working?

Q: Are there any particular policies or measures in the last year, either locally or nationally, that in your view have helped or hindered public health in general?

Topic Guide D – Service Providers

Q: About your role

Q: How long in post

Q: What are the main aims of the service and who are the target population?

Q: Is partnership working a major feature of service delivery?

Probe: if not why?

Q: Who are the main partners they work with?

Probe: in what capacity they work with major partners?

Q: What are the main benefits of working in partnership?

Q: In what ways have the partners helped the service in respect of:

- The development of the service
- Assessment of need (e.g. joint assessments)
- The funding of projects
- The organisation/implementation of projects
- Helping to identify and/or access target populations

Q: Is partnership working a feature in all levels of the organisation from senior/top management to frontline staff?

Q: Are there barriers to working in partnership?

Probe: if there are, what are they? How can they be overcome? For example: language, culture, power plays, relationships, changing structures and/or personnel.

Q: Could aims and objectives of the service be delivered to the same standard without working in partnership?

Probe: if not, why?

Q: Is there any overlap or duplication of services?

Probe: if so, how can the overlap be overcome through partnership working? Is overlap necessarily a bad thing to be avoided at all costs?

Q: Are all partners aware of their roles and responsibilities?

Probe: if not, which partners not aware and why

Q: Do partner agencies share information?

Probe: if yes, what types of information sharing? If not, what are the barriers?

Q: What successful outcomes for service users can they deliver as a result of working in partnership?

Probe: what constitutes 'successful' or 'effective' partnership working? Can they give any examples? i.e. clear vision, realistic aims and objectives, commitment of each partner, high levels of trust, clear lines of accountability, good communication.

Q: How much is the partnership based on 'goodwill'?

Q: Does organisational change hamper effective partnership working?

Probe: if so, in what ways?

Q: Do all partners know about the service they provide in detail or are some more knowledgeable than others?

Q: Is working in partnership a requirement of funding bids?

Q: Does bidding for funding create tensions among other partners who may be bidding for the same funding?

Q: Do the financial, time and human resource costs of partnership working justify the means in terms of outcomes gained?

Q: What help is required from the Council or PCT to enhance service provision?

Q: Do they feel the Council/PCT is wholly committed to the service?

Q: Are the aims of the service part of an LAA target in their area?

Probe: if yes, in what ways are they working with the council to meet the target?

Q: In what ways could partnership working be improved to enhance service provision in the future?

Topic Guide E – Service Users Focus Groups

Q: Why did they use this particular service provider?

Probe: locality, recommendation, 'word of mouth', referral etc.

Q: Who runs the service (i.e. Council, NHS, voluntary provider)?

Q: Do they know of any other provider offering the same service?

Probe: what prompted them to use this service?

Q: How long have they been using the service?

Q: What are their impressions of the service thus far?

Q: Is the service in-line with their initial expectations?

Probe: if not, ask for reasons why

Q: Have they used a similar service in the past?

Probe: if so, how do they compare.

Q: Do they believe there is any overlap or duplication in service provision in the area?

Probe: do they know whether these services work together? Is the overlap/duplication, if it exists, a problem?

Probe: if so, what are their views on these services working in partnership?

Q: Are there any gaps in the provision of services in their area?

Probe: if yes, what are the gaps in provision and how could these be addressed?

Q: What improvements would they like to see in the service they are using?

Probe: what are the most effective aspects and what are the areas or gaps that need addressing?

Q: Are there clear referral pathways to other services if needed?

Probe: if not what are the problems with referral?

Q: Do they feel the services they use could work together more effectively?

Probe: If so, ask for examples.

Addendum:

This document is an output from a research project that was commissioned by the Service Delivery and Organisation (SDO) programme whilst it was managed by the National Coordinating Centre for the Service Delivery and Organisation (NCCSDO) at the London School of Hygiene & Tropical Medicine. The NIHR SDO programme is now managed by the National Institute for Health Research Evaluations, Trials and Studies Coordinating Centre (NETSCC) based at the University of Southampton.

Although NETSCC, SDO has managed the project and conducted the editorial review of this document, we had no involvement in the commissioning, and therefore may not be able to comment on the background of this document. Should you have any queries please contact sdo@southampton.ac.uk.