Partnership Working in Public Health: the implications for governance of a systems approach

Short title: Partnership working in public health

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Background

A public policy paradox is the significant emphasis placed on partnership working to secure effective policy and service delivery in numerous sectors despite the evidence testifying to how difficult it is to make partnerships succeed and add, rather than consume, value. Partnership working is difficult work and often 'high maintenance'.[1,2,3] If this is so in respect of health and social care, where most of the research on partnerships has been undertaken, the challenges are multiplied many times over in respect of the 'wicked issues'[4] with which public health is largely concerned. Wicked issues are difficult to define, usually have no clear solutions, are interdependent and multi-causal, are socially complex, and rarely sit within the boundaries or responsibilities of any single organisation. Tacking such issues – for example, obesity, sexual health, alcohol misuse, worklessness – axiomatically transcends a diverse range of professional and organisational boundaries and often at multiple levels. Furthermore, wicked issues are often contested, being framed variously by different stakeholders, and the evidence base in respect of effective interventions is either lacking or unable to connect with practitioners in a way that enables progress to be made in particular contexts. Given the prevalence of 'wicked issues' in public health, we drew on systems thinking, and on the specific notion of complex adaptive systems, to frame the study reported in this paper.[5]

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's[6] 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 system that meets it. So, in accordance with 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 possibly not through pre-existing and bureaucratic partnership structures that themselves may militate against finding new ways of tackling complex problems. A systems perspective challenges 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.

Partnerships became especially popular around the mid-1990s, and the arrival of New Labour in government, 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 and language 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.[7] 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. As Pollitt[8] notes, while a succession of policy statements and white papers give the impression 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.

Despite the sizeable body of research that now exists on partnerships, most of it is confined to issues around process and structure rather than outcome. Being able to establish the link, if any, between partnership working and outcomes for service users is notoriously difficult to do with any confidence – a case, as Powell and Dowling put it,[9] of 'the indefinable in pursuit of the unachievable'. Yet, as the UK coalition government places greater emphasis on health outcomes in preference to targets as a way of assessing performance, the need for a shift of focus has possibly never been greater.

The study described here attempted to explore partnership working in public health from this critical perspective.[10] Although the study was conducted when the organisational architecture and landscape was rather different from the one presently being created, and centred on primary care trusts (PCTs) having the lead role to improve public health, the key findings have implications that remain relevant and are transferable to the new architecture being fashioned around Health and Wellbeing Boards (HWBs), clinical commissioning groups and other features of the move of public health to local government where in future directors of public health and their specialist teams will be located.[11]

The research on public health partnerships, conducted between 2007 and 2010, had three 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).*

Methods

The sheer variety of partnerships can be bewildering and possibly nowhere more so than in public health. In conducting the research, a decision was taken not to define the term ‘public health partnerships’ too tightly preferring instead to allow our respondents some leeway in talking about the partnerships with which they had most contact and with which they were most familiar. In practice, most partnerships fall into one of three categories:[12] *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. The study focused on local strategic partnerships (LSPs) and local area agreements (LAAs) which are examples of the first type of partnership – facilitating. Such partnerships operated in England between 2007 and 2010 with the aim of creating a framework within which local partners could work together more effectively to secure the economic, environmental and social wellbeing of their area.[13] LAAs’ purpose was to strike a balance between the respective priorities of central and local government and their partners in reaching a consensus on how area-based funding will be used. It is unclear if LSPs will survive the changes underway in health care and public health or whether they will be replaced by the new HWBs.

The research was conducted in 2 main stages. Stage 1 involved a systematic literature review of partnerships in public health. The results from this have been published separately and for reasons of space are not reported at length here.[14] Issues, themes and gaps identified in the review were then explored in Stage 2 for which nine case study sites were selected across England based on PCT boundaries with matching local authorities according to the strength of partnership working – high, medium, low – with three sites in each category. The field sites were chosen in consultation with members of the Local Government Improvement and Development's (LGID, formerly the Improvement and Development Agency) healthy communities team and the selection was informed by the team's peer review benchmark which comprised four themes: leadership, empowering communities, making it happen, and improving performance.[15] Our research findings in the nine sites concur with the LGID's ranking of their performance in regard to partnership working.

There were three phases to stage 2. First, 53 face-to-face semi-structured interviews were conducted with senior managers and elected members in the selected 9 locations. The sample was chosen to cover key roles in partnerships. Second, follow-up telephone interviews were conducted after some eight to 12 months with eight out of the nine Directors of Public health in the study sites. Finally, four tracer issues (smoking cessation, obesity in children, alcohol misuse and teenage pregnancy) were identified from four of the study sites involving semi-structured interviews with 32 frontline practitioners, and four focus groups with service users in three of the locations to establish how far strategic level partnerships impacted on their work and outcomes. The issues were selected on the basis of their significance to that local area in the context of their LAA and the priority of the issue within the agreement.

Results

The study revealed a range of issues concerning partnerships and their operation in the public health sphere. Many of these have featured in other research on partnerships and therefore contain few surprises. But there were a few less common findings which offer important insights into why public health partnerships struggle to make the connection between the strategies, such as LAAs, produced through mechanisms like LSPs and what happens on the ground where services and their users interact and get delivered.

Determinants of successful partnership working

With few exceptions, our respondents regarded working in partnership as providing a co-ordinated approach to tackling public health issues that was a prerequisite of effectively resolving such issues. The major benefit to service users was perceived as 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 from policy formulation to practical everyday contexts, by sharing knowledge and expertise of partner agencies. A particular benefit, though often difficult to realise, was sharing information between agencies and having established information sharing protocols in place.

Three factors were reported to govern an effective partnership: (a) a partnership that is clear about its goals and objectives, (b) partners who are aware of their roles and responsibilities, and (c) a partnership that has a clear strategic overview of how it is performing through robust monitoring and evaluation. As a director of civic engagement explained: ‘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'.

But making it all work and acting as the glue that held everything together was the existence of goodwill between partners. As a deputy director of commissioning put it: 'underpinning all of that 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'.

The importance of goodwill was especially evident at frontline level. Allied to this feature was the existence of 'local champions' who played a crucial role in partnerships. Their particular contribution lay in their commitment and enthusiasm which could, in turn, encourage others to commit to partnership working.

Barriers to partnership working

Alongside the perceived benefits of partnership working were a number of barriers. In particular, different agency priorities were evident and could negate, or limit the potential of, effective partnerships. Some elected members in particular were wary of partnerships and disliked the word because, in the words of a strategic director of children and young people's services, 'it means power being taken away from them'. Genuine partnerships demand a degree on interdependence and that can mean giving up power for the greater good.

Second, good information sharing protocols were not in place with the consequence that users did not receive a seamless service but were instead often being re-assessed by a succession of separate services. This problem had its roots in two issues: partners were not clear about their respective roles and responsibilities, and there was a failure to ensure that targets were shared and owned by the partnership so that agencies did not simply disengage at the moment when their own specific targets and priorities were at risk or became pressing. A deputy director of public health described the dilemma as follows: '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'. Such a culture then 'becomes a major barrier' to making partnership working work.

Most partnership working is conceived of as requiring horizontal linkages but vertical links are equally, if not more, important. A common barrier was the absence of a connection between the fruits of partnership working at strategic level – namely, the LAA – and the work of frontline practitioners which often went on in complete isolation from, and regardless of, the goals and objectives agreed at the higher level. As a public health consultant said: 'writing it on paper doesn't necessarily make it happen'. It worked both ways since the goals and targets governing the work of frontline practitioners ought to have been fed into, and aligned with, the LAA goals and targets. The absence of ownership resulted in many LAA targets being regarded as unattainable. One director of public health noted that although partners seemed aware of their responsibilities, '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 necessarily happen'.

Partnerships and LAAs

Although our nine selected field sites had all produced LAAs, and to that extent could be seen to have delivered on the partnerships established to formulate these, the degree to which they had an impact 'on the ground' and could be seen to have been delivered was less encouraging. For success to occur, and picking up on the barriers to partnerships sub-section above, joint delivery plans had to be aligned with the LAAs and this proved more difficult in practice to achieve. For many of those interviewed there was a sense that a strong alignment did exist between the LAA and what the PCT had identified through world class commissioning as its priorities. But for others, there was an absence of assurance that appropriate systems and processes were either in place or working well. One deputy director of policy and performance claimed that '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'.

Partnerships and outcomes

The prevailing view expressed by our respondents was that policy and procedures were overly bureaucratic; that the bureaucracy meant time delays were inevitable in decision-making; and that policy needed to be more outcomes focused. In the words of a director of commissioning: '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…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'.

Although it was accepted that a degree of bureaucracy was probably unavoidable, there was a view that partnerships could all too easily get 'bogged down' in process issues with the attendant danger that they would lose a focus on outcomes and become little more than 'talking shops'. One director of public health said that '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'. But even if the partnerships focused on outcomes, it would be all but impossible to isolate with certainty whether it was the partnership that was the cause of success or something else. As a director of commissioning put it in the context of teenage pregnancies and what might account for an improvement in respect of the four or five strands that constituted an intervention: 'I'm not sure we could say which one of those four or five strands was delivering that improvement. Some of it relies on partnership, some of those [strands] don't, but it would be quite hard to isolate whether it was the partnership that was giving them success'. At best, it was suggested that the partnership acted as an enabler for the delivery of outcomes. And for some of those interviewed, it did not matter if the partnership did not deliver the outcome as long as the outcome was delivered.

But overarching the whole issue of partnerships contributing to improved outcomes was a common complaint that the 'how are we doing' question rarely got asked and almost never got answered. One director of public health said they had 'really struggled…to get the whole of my public health information people to answer that question'.

Relationship with central government

The general perception among our respondents was that central government should avoid active involvement with local agencies such as local authorities and PCTs. Too many initiatives ('initiativitis'), too many targets ('terror by targets' culture), too much policy and organisational churn caused by constant reorganisation, and an over-bearing top-down policy approach which denied local engagement were all perceived as having a detrimental effect on partnerships, preventing them from fulfilling their roles and responsibilities. A programme director with a health partnership was unequivocal: '[It would] 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'.

Respondents wanted to see more joined-up policy responses from national government in order to avoid mixed messages being received locally as a result of different government departments being at cross-purposes or giving contradictory advice or instructions. They also wanted more space to focus on local needs and concerns which were not necessarily the same as those imposed from the centre. As a consultant in public health complained: 'things that we should be paying attention to aren't getting attention because they're crowded out by must-dos that are centrally dictated'.

Discussion

There are few signs that partnership working has had its day or is in decline and no signs that the trend towards establishing new partnerships is abating. Equally, in true path dependency fashion,[16] it seems as if the same weaknesses and mistakes are all too likely to be repeated unless careful attention is paid to the implications of the findings from studies such as this. Sense-making about partnerships reveals a paradox that lies at the core of any assessment. While on the one hand partnerships are seen to be a prerequisite of tackling 'wicked issues', on the other hand they seem unable to break free from the silo-based structures which govern how public services are organised and delivered. Against such a context, partnerships can seem like the veneer or overlay on a set of organisations and practices each with their own histories, cultures and preoccupations. Hardly surprising, therefore, if partnerships often seem to be designed to avoid any loss of power from their members rather than effectively pooling power and resources so that the whole becomes greater than the sum of the parts.

A number of key messages emerge from the study and with new partnership forms being actively debated and created as a consequence of the government's NHS and public health reforms,[17,18] the time is opportune to stand back, reflect and perhaps try and apply some of the learning that research has to offer but which invariably gets ignored in the rush to deliver. What is needed is less of the 'can do' culture prevalent among public service managers and more reflection on how partnerships might best be constructed for the tasks facing them.

Many of the messages from the research reported here are not especially novel but combined they add up to a significant agenda for change which demands a new approach and some fresh thinking as well as letting go some accepted practices which do not appear to have helped partnership working deliver. Although partnership working received positive endorsement in the main from our study sites, digging a little deeper into its processes and structures reveals a more mixed picture which begins to question the need for some of the existing, and often over-engineered, partnership structures. They may endeavour to be all inclusive but can at the same time become unwieldy and overly complex and cumbersome. Six lessons, or pointers for policy, have been drawn from the research.

First, policy and procedures need to be more streamlined with an emphasis on outcomes rather than simply expending energy and effort on process and structure which alone are insufficient to justify the significant transaction costs partnerships incur. Although the study did not identify any partnerships that could be said to be a model of perfect functionality, those deemed to be successful by our respondents 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 careful monitoring. The government's emphasis on public health outcomes is not lost on those who believe that the new partnership forms being established (eg HWBs) offer an opportunity to work in new ways.[18]

Second, perhaps those operating at a higher strategic level in partnerships could learn from some frontline practices which operated in a more organic and integrated way. This was in contrast to approaches at a higher strategic level where the emphasis was much more formal and focused on target-setting and delivering on key themes. Partnerships on the front line responded to service users' real needs and concerns rather than a target which may, or may not, align with users needs. The issue may simply be about aligning relationships between the different levels where often there is a failure of communication.

Third, partnerships tend in practice to be rather messy constructs with no clear causal relationship between what they do and what the partner organisations achieve by way of outcomes. As our systematic review of the impact of partnerships on public health outcomes in England between 1997 and 2008 concluded, the 15 studies meeting the criteria which were reviewed showed little evidence of the direct health effects of public health partnerships.[14]

Fourth, there is a powerful tendency at work to over-engineer partnerships ensuring that systems, membership and structures are in place by way of ensuring good governance but often to the exclusion of being clear about purpose and achievement and the extent to which the partnership aids or hinders their fulfilment. A key decision to make at the outset is whether the partnership is viewed as a representative forum or as an arena for people to think afresh about how to tackle the wider health agenda. Also, not all partnerships need be seen as semi-permanent fixtures or as existing in perpetuity. Perhaps they need only exist for as long as the task for which they have been set up to tackle remains to be resolved. Problem-based partnerships ought therefore to be dissolved as soon as their work is done.

Fifth, and linked to the above, what emerged above all else from the research was that structures are less important than relational factors such as trust and goodwill. If this is the case, then it may seem odd and a displacement of effort to focus so much on structures which is invariably what happens in practice. There is a risk of this happening again in respect of HWBs although also an acknowledgment on the part of some local areas that repeating past errors must be avoided and new ways found to make partnerships work.[18]

Sixth, is the importance of leadership and the need to emphasise and prepare potential leaders in collaborative, integrative and adaptive leadership as a means of nurturing joined-up working.[19,20,21,22] Leadership that derives its legitimacy from operating across organisations and at their boundaries involves difficult and intricate tasks. Boundary-spanning leaders remain the exception although with a greater focus on integration across health, health care and social care it is likely we shall see more attention devoted to developing a cadre of such leaders in future.

Finally, and linked to all of the above learning points, complex systems thinking around how wicked issues can best be tackled suggests the need for a different approach to partnership working, and one that is looser, more flexible and responsive to rapidly changing contexts, and, above all, less over-engineered. Too often if partnerships are not seen to be working, the temptation is to resort to a structural or mechanistic approach by proposing that the partnership be made statutory, or by strengthening monitoring arrangements to ensure that the partnership delivers what it promises. Tinkering with existing arrangements and constructs may provide temporary or minimal relief at best.

Systems thinking does not offer a panacea or magically make complex problems disappear. But through adopting a systems perspective, the process of designing, formulating and implementing policies is based more on facilitation of improvements than on the control of the organisation or system. As Chapman[23] puts it: 'the aim should be to provide a minimum specification that creates an environment in which innovative, complex behaviours can emerge'. Moreover, with reference to the leadership issue mentioned above, 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 and possessing all the answers.[24] Building partnerships through the adoption of a systems perspective requires different skills to enable them to work.[25]

Given the notion of complex adaptive systems[26] which was adopted to frame the research, an issue is whether the model of partnerships that has arisen in public health around LAAs and LSPs and their variants is the only or optimal model or whether there are other approaches that might achieve more and at less cost. The question takes on a greater urgency when existing partnerships in England are being replaced by new ones in the form of HWBs. The architects of these Boards would do well to heed the findings from the study reported here and also the words from an Institute of Government report on how government how government can perform better:[27]

'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 comes, at least in theory, from competition, conflict and even a little chaos at the margin'* (emphasis added).

A similar argument is articulated by Leadbeater[28] who maintains that the problem of sclerosis in public services can be put down to public organisations having been designed as bureaucracies to process large numbers of cases in identical ways. A feature of such organisations is their division into 'professionally dominated departments with activity concentrated into narrow specialisms, with little cross-fertilisation of ideas or practices'. Generally, as a consequence, 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. As was noted in an earlier section, trust and goodwill comprised the glue that made partnerships work. Overall, strong trust is equated with long-term stable relationships which have become virtually impossible in public services which appear to be caught in a cycle of continuous change with their staff experiencing constant churn. Leadbeater argues that perhaps the belief that trust can only be present where long-term sustainable relationships have been nurtured and allowed to survive is over-stated and may provide a convenient excuse for partnership failure. He asserts 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 intensely'.[28] Conversely, he suggests that long-term trusting relationships, where they do still exist, risk becoming cosy and collusive affairs that result in problems of their own that, paradoxically, make long-term, mutual trust the enemy of creative and innovative joint working.

Conclusions

Partnership working is not going to disappear. The complex challenges facing those in public health are unlikely to disappear either or become less complex. Regardless of how we configure our public services and regardless of whether public health is located in the NHS or, as proposed for England, local government there will always be a need to bring together a mix of skills and organisations who left to their own devices would probably not seek to work together. But working across boundaries is a means to an end and not an end in itself. It sometimes seems as if this simple truth is forgotten. Even those working in partnerships concede that often what passes for genuine interdependence and working together is the production of a strategy that then fails to get picked up.

For partnerships to work, there are actually very few simple rules to follow. These are:

- Have a clear purpose with common aims, goals, objectives
- Bring together the right partners who can contribute most and commit

- Be able to have an honest dialogue about each partner's contribution
- Invest in building trust and relationships
- Invest in leadership of the right sort which demands working across silos.

The dilemma is that we find adhering to such rules so difficult to achieve in practice. But unless we do so, we may not move beyond the definition of a partnership as 'consisting of the temporary suppression of natural loathing in the interests of mutual greed'.[29]

As we have argued, partnership working in future may benefit from a looser and less structured approach. 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 Vangen[30] call a 'working path'. From such modest beginnings a clear purpose and common aims (the first rule listed above) may emerge over time but in the initial stages partnerships might benefit from being more exploratory, tentative and incremental with both pre-set (where possible) and emergent milestones governing their progress. Importantly, the structural arrangements put in place should be just sufficient to allow adequate exploration of the unknown. As Edmonstone[31] 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 the problems being confronted in public health are examples of 'wicked issues' which demand a new and different approach to managing change.

In keeping with what some of our respondents reported in interviews, partnerships 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.

If the research reported here is to be of any value and have an impact it needs to catch the tide and while this can rarely be planned for or anticipated with any accuracy, when it does occur it can offer a window of opportunity to break out of accepted mind traps and do things differently. With the move to new types of partnership uppermost in the minds of many in local government and the NHS, maybe there is just a chance that what happens in future will not be a repeat of the past.

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