Managing Partnerships for Improving Health and Well-being

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ACKNOWLEDGEMENTS

INTRODUCTION

Since October 2005 a research team from Glasgow University's School of Business and Management has been carrying out research funded by the Glasgow Centre for Population Health to examine the progress of partnership development and early indications of performance in a Glasgow Community Health and Care Partnership (CHCP). This summary outlines the purpose of the research, key findings, implications for CHCP management, and ongoing research and staff development activities.

There are two important contextual factors for the findings presented within this report. The first is the high level of health and social problems that exist in the area. The second is that the management team from the outset intended that the first year of the CHCP should be relatively stable i.e. no dramatic changes, to enable structures, processes and relationships to form and build before entering any implementation phase for service change. The findings should therefore be read with this in mind, and reflect the progress that has been made within these challenging circumstances.

A copy of the full research report is available on the Glasgow Centre for Population Health website (www.gcph.co.uk/content/view/124/119/) and a hard copy can be provided on request from Jane Mackinnon.

AIMS AND PURPOSE

The project set out to evaluate the CHCP's partnership progress and early indicators of partnership success focussing in particular on:

1. the clarity and acceptance of partnership working;
2. the progress made in different service areas within the CHCP;
3. the nature and development of inter-agency trust; and
4. the way in which organisational and professional identity was developing and changing in light of the unified CHCP structure.

APPROACH AND METHODS

The research included a CHCP-wide survey, observations at CHCP management meetings, and interviews with 36 managers and professional representatives. In addition to this around 80 interviews were completed with staff in four service areas within the CHCP where there existed different levels of integration between health and social work staff. Working with staff at all levels of the CHCP enabled the researchers to gain an in-depth understanding of the processes of partnership development.

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FINDINGS AND CONCLUSIONS

The research examined CHCP developments from the outset of the new structures and was able to assess the extent to which pre-conditions for successful partnership were evident and also staff perceptions about potential barriers. The findings reported here relate to the period October 2005 to October 2007. At this stage it was too early to measure 'outcome successes' such as enhanced efficiency or improvements to service users. This summary outlines some of the key 'process' issues emerging from the research.

Positive pre-conditions for successful partnership

1. Staff see the potential of partnership working for service improvement
The study found that partnership working was widely recognised as potentially beneficial to staff and service users, through information sharing, improving access to services, and bringing multi-disciplinary perspectives to tackle complex problems.

2. Staff were open to new ways of working and organisational change
The CHCP demonstrated a number of positive characteristics such as willingness to change, openness to scrutiny, being reflective of practice (demonstrated not least by the access given for this research), and resilience in the face of the demands made upon staff by the inevitable process of ongoing change.

3. A high level of trust among peers across agencies was evident
The study also found a high level of trust between peers working within multi-disciplinary teams, which is recognised as a real strength and a pre-requisite for effective partnership working.

Potential obstacles for successful partnership

1. Culture clashes between agencies
There was some uncertainty (or scepticism) about whether the overall CHCP vision could be realised between such culturally different organisations, characterised by sub-cultures of strongly formed professional groups. Furthermore the disparities between health and social care in terms of pay, and of organisational culture, have served to highlight differences rather than the complementary features of the organisations.

2. Confusion about roles and structures

In terms of establishing clear and robust partnership frameworks, the research found that there was a degree of confusion about the roles of various groups and committees – although this reflected the early stage of CHCP development and was becoming clearer over time.

3. Lack of staff capacity

Significant issues were raised in relation to the capacity for change and partnership working, although willingness to change was clear in many areas. It has previously been shown that partnership capacity is needed not just during initial changes, but on an ongoing basis as part of individual's working reality. Creating a common language with other professions, engaging in service reconfiguration, and conducting day-to-day service delivery in consultation with others, represents both a direct cost (time taken) and an indirect cost (in terms of what else could be done with the time) and it is essential that staff come to a reasoned view about what proportion of time partnership working should take.

It is important to note that the capacity for change and for partnership working in partner organisations will not be the same at each point in time. Depending on the issues each faces individually, progress may differ within each service area of the CHCP. Change and organisational development activities will need to take account of these differing capabilities and capacity for change.

4. Integration or co-location – who, why and how far?

There was a clear sense that many members of staff have concerns that increasing levels of integration between health and social work teams threatened to erode their sense of professional identity. Co-location was found to have in some cases 'forced' staff to overcome professional differences, and to do so successfully, albeit over some considerable period of time. Elsewhere, however, it has further highlighted differences between organisations and occupational groups. Although perceived as beneficial overall, it was not yet clear to all staff whether service users benefit directly as a result of co-location, and staff frequently questioned whether there was an evidence base for integration. This suggested that there was a need to be clear about the type and level of integration envisaged. This was a particularly important and prominent issue for staff. There was a degree of uncertainty among staff about the end point of integration and in particular what this might mean for staff roles. Linked to this were concerns that some of the structural changes had fragmented certain professional networks and left some staff with a sense of isolation and concerns around sharing professional knowledge in their day to day work, as well as having an impact on their continued professional development opportunities.

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5. Staff have adopted a 'wait and see' policy with regards to trust in senior management
One issue for the CHCP was in relation to the level of trust in senior management.   Staff displayed high levels of trust in their peers, but at the time of this research senior managers had had little time to demonstrate achievement and therefore limited opportunity to gain trust from others based on evidence of competence, knowledge, professionalism, consistency and fairness. Staff were watching closely to see how senior management delivered against expectations, particularly in relation to the views expressed by staff during consultations on CHCP developments.

Maintaining trust is an important ongoing issue, particularly at more senior levels of the organisation. Decisions about resources and priorities, coupled with future debate and evaluation of performance, are likely to pitch one service area against another and to highlight the tensions between trusting colleagues and engaging in the political exchanges that characterise organisations.   At the time of the study, there was no 'risk' as such and trust had not been tested. Moreover, the way in which these senior decisions are played out will affect perceptions of whether there is a 'take over' from one organisation or another or whether there is a 'merger' within a context of equal power and influence.   This will in turn consolidate or undermine trust among management and the wider CHCP staff group.

RECOMMENDATIONS

The findings highlighted a considerable opportunity for management to take the development agenda forward but placed an onus on the openness of communication and the identification of some clear early wins if partnership working was to be considered worthwhile. Because there was a deliberate intention on the part of the CHCP management to ensure a 'steady state' within the first year, it is unsurprising that many front line service staff had seen little change to their daily work and were unclear about what was required of them and what the CHCP might deliver. However, as the CHCP moves into the change implementation phase, there are a number of issues that can be built on from the research as a focus for change management activities. Particular aspects highlighted in the report were the need to:

- create a sense of inter-dependence between staff if partnership is to be considered necessary;
- recognise the impact of partnership working on job demands;
- address issues of capacity for change, and
- ensure that issues of professional identity are addressed in such a way that the perceived 'erosion' of professional identity is not an ongoing barrier to change.

Overall, the research highlighted a number of issues that senior, middle and operational managers can use as a basis for discussion and organisational development activities.

It has been clear from the first phase of the research that many of the findings are related to the actual focus of integration and performance in the minds of staff and policy makers. As expected given the initial period of stability set out for the CHCP, much of the emphasis had necessarily been on integrating systems and staff, i.e. structural change, and the changes were not yet being viewed primarily from the point of view of the service user. As a consequence, staff talked about partnership working in terms of bringing multi-professional perspectives to a problem. As the CHCP continues to develop, a shift towards discussions that focus on the service developments from the perspective of the service user would potentially lead to a different set of conversations; in other words, moving from a provider/service led culture to a service user-centred approach that reflects the real ethos and beliefs of CHCP staff. Such discussions, centred on improving outcomes for the service user, might create a vehicle for moving beyond the early challenges of multi-disciplinary working in integrated teams and enable staff to form a joint vision for future service delivery.

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