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PARTNERSHIPS UNDER PRESSURE

A commentary on progress in partnership-working between the NHS and local government

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Partnerships Under Pressure

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The King's Fund has a long-established interest in partnership-working as a means of improving services to people with long-term illness or disability, and, between May 2001 and March 2002, undertook a review of partnership policies with the help of an expert panel whose members have experience of developing and implementing policy. This paper offers a commentary based on the meetings of this group.

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Executive summary

This report provides a commentary on the progress being made by the NHS and local government as they work together to improve services for older people and people with long-term illness or disability. The views expressed are those of the King's Fund, drawing on discussions in an expert group convened by the King's Fund to review the implementation of partnership policies. The paper highlights encouraging progress in partnership working but also points to some areas of concern. Nine key recommendations are proposed to address these issues.

This commentary focuses on formal partnerships ranging from strategic partnerships for planning services through to partnership working in teams to deliver services to individuals and families. A distinction is made between those partnerships that have some agreed rules of engagement, and mergers between organisations such as in care trusts. We are reviewing partnerships where people work together around a shared purpose, across services and systems.

Progress in partnerships

This snapshot shows positive signs of progress across the NHS and local government:

- people no longer questioning whether partnerships are important, rather focusing on how best to make them work
- recognition by statutory, voluntary and private sectors that action by one organisation will have a knock-on effect on the other and the importance of a whole systems approach to best meet the needs of users and carers
- increased working together to develop joint strategies and agree joint plans
- examples of new teams of health and social care staff working together
- different models of integrated care emerging for different service users.

Challenges ahead

Although these are important steps forward, developing partnerships face a number of challenges. These include the impact on partnerships of hospitals in crisis, perverse incentives, continuing reorganisation and financial pressures, and the extent to which frontline working has changed.

- **Hospitals in crisis**

There are concerns that developing partnerships are under increasing pressure from a growing mismatch between Government aspirations and local priorities. The relentless push from Government to solve pressures in the service system that primarily benefits acute health services is distorting partnership working, and diverting attention away from other activities that are also needed to directly improve outcomes for users and carers. Incentives to reduce emergency admissions and delayed discharges from hospitals are stronger than those relating to the co-ordination of housing, primary health, social care and other community services.

- **Perverse incentives**

There are a number of perverse incentives in the system. Performance monitoring and star ratings need to be more broadly based if they are to support radical steps on the ground to move beyond

the agenda to take pressures off the acute sector. Audit and performance management systems are not fully joined up which, at best, involves duplication and, at worst, undermines local attempts at partnerships. While there may be merits in care trusts, there are dangers that these new structures threaten 'shotgun marriages' or incentive-led national models rather than supporting sustainable joint-working relationships. Any 'quick fixes' to address problems with a high political profile can divert local agencies from working together on local priorities.

■ Continuing re-organisation

Partnerships face considerable pressures in addition to these tensions between central and local priorities. They are hampered by organisational changes within both the NHS and local government, which disrupt relationships within and across organisations, including joint working with voluntary and private sectors. Financial pressures on both sides undermine the development of partnerships where there are fears of inheriting the other partner's deficit or losing financial manoeuvrability.

■ Change on the frontline

There is some way to go before cultural change is achieved at every level of the partner organisations, particularly at the frontline where different professional worlds and inter-professional relationships impede partnership working. Middle managers are caught between meeting explicit corporate responsibilities and adopting new, flexible ways of working. They are expected to be leading change agents, often with inadequate training and support, and at the same time fulfil routine operational responsibilities. Different practices in commissioning; underdeveloped integrated support systems; pressing staff shortages within health and social services; and support by elected members and non-executives – all present further challenges to cultural change.

■ Resource pressures

The picture of partnership working is complex. Different models of integrated care are emerging for different care groups, reflecting varied policy drives and resources. Partnership working is still seen primarily as the remit of health and social care. We have yet to see the full integration of a range of local government functions and the independent sector into health. There are indications that, in some areas, current pressures on the NHS and local government are tempting partners to relinquish major responsibility to the other. Dubbed 'sloping shoulder' partners, these organisations appear to be content to play less than their full part in achieving better-integrated care and support, in particular, for people with mental health problems or learning disabilities.

Evaluating partnerships and their outcomes

There is little evidence to date about the impact of different models on the lives of service users and carers. Much remains to be done to assess the effectiveness of partnerships and to bring together local experience, different strands of research, feedback from service users and carers, and information from national and regional inspection and monitoring.

What has changed in partnerships over the last year?

What does appear to have changed is the intensity of Government pressure to show results and to shift the emphasis from improving the health and well-being of vulnerable people to a more

narrow pre-occupation with solving problems in acute health services. This is particularly damaging for some of the innovative partnerships which have developed between social care, community health services and primary care, and who see their shared agenda high-jacked to serve the interests of the acute sector who are often the least concerned with partnerships. The Government is pushing an agenda for change and expecting demonstrable outputs within months. Any cycle of change is more likely to take years.

Increasing support and incentives

While there is an urgency to improve and integrate services, pressures on all the partners and the fragility of many partnerships suggest the need for increased support and incentives. There are dangers that partnerships will fail to deliver better-integrated services for vulnerable people if the push for change is too fast and the objectives too circumscribed by central government.

Recommendations for supporting partnerships

1. There is widespread support for Government policy on partnership working, integrated services and quality user-centred services, but time is needed to deliver this locally and any further initiatives compelling partnerships or new structural arrangements should be resisted. Local partners need greater freedom to identify and manage their own partnership objectives beyond solving problems in the acute health sector. In return, local authorities and their health partners will need to show evidence of progress in establishing sustainable partnerships, improved services and impact on the quality of people's lives.

2. As part of demonstrating progress in partnerships and their outcomes, ongoing work to review performance assessment needs to check:

- whether current indicators are appropriate for the outcomes which partnerships seek to achieve
- where efforts are being duplicated by partners to fulfil the separate monitoring systems
- how this framework can be used for purposeful monitoring of partnership working through joint reviews and joint monitoring.

3. Serious consideration should be paid to avoid building in penalties which might damage partnership working. Instead, the emphasis should be on providing incentives to partnership working. One possibility may be offered through Local Public Service Agreements where a local authority's commitment to deliver specific improvements in performance may be in partnership with health. As part of the agreement, the Government would commit to reward these joint improvements. This approach could provide both a financial incentive, in the form of reward grants, as well as support a focus on outcomes where these agreements concentrate on results rather than processes.

4. Under-resourcing of social services seriously jeopardises the partnership agenda, particularly where budgets are skewed by the demands of children's services. Funding for social care needs to be increased to a level commensurate with the workload expected and to allow for investment in early preventive services.

5. Further organisational changes in any of the partner organisations should be avoided for at least the next two to three years and proposals resisted to reorganise in order to improve delivery of services to families and children. This will allow for the establishment of primary care trusts

(PCTs) and other developments to modernise services so that strong local networks and relationships between the key players have every opportunity to mature.

6. Change needs to be resourced in its own right so that staff are fully trained and there are dedicated individuals to provide the leadership needed within and across the partner organisations. Investment in leadership development for middle managers is particularly important. Partnership working also needs to be included in national, professional training courses.

7. Further central support should be given to help solve problems in harmonising terms and conditions for staff and information management, and technology systems across health and social care.

8. User empowerment is an important driver for cultural change and support should be given to progressing local involvement of service users, carers, patients and the public in ways which cuts across service boundaries and engages those people who are often excluded. Financial and other support should be provided to ensure vulnerable people are properly engaged in partnerships between the NHS and local government, in steering developments and monitoring and evaluating progress.

9. In order to assess the benefits for service users and their carers, it will be crucial to bring together learning from the field, as well as recent and ongoing research which illuminates what is happening with respect to the outcomes of partnerships.

Introduction

The King's Fund has a long-established interest in partnership working as a means of improving the delivery of services to people with long-term illness or disability. The Government has put partnerships between the NHS and local government at the heart of delivering better-integrated services. The King's Fund is reviewing the implementation of these partnership policies with the help of a partnership review group, whose members have expertise and experience in developing and implementing policy from a range of national and local perspectives (see Appendix 1 for a list of members). This paper offers a commentary based on meetings of this group, who have reviewed progress from May 2001 to March 2002, highlighting moves forward but also pointing to some areas of concern.

This paper offers a snapshot of progress on partnerships. It points to local partnerships under pressure and warns of the dangers of approaches that could set back partnership working and ultimately fail to deliver better integrated services for vulnerable people.

What do we mean by partnerships?

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

This paper is primarily concerned with formal partnerships, ranging from strategic partnerships that plan and commission services through to service delivery teams involving health and social care staff. These are 'formal' in the sense that the relationship between organisations or professionals has some agreed rules of engagement. A distinction is made to differentiate these partnership arrangements from mergers between organisations, such as in care trusts.

We are considering partnerships where people are working together around a shared purpose, across services and systems, moving away from old 'vertical' models of service provision to 'horizontal' processes. The focus is on partnerships that go beyond relatively small scale, ad hoc arrangements to partnerships in the mainstream that are often attempting to address the 'wicked issues'. These are issues where the problem is hard to define, causal chains are difficult to unravel and complex interdependencies are involved.[1] In such partnerships, interactions between partners and networks are more important than organisational boundaries and structures.

What will this 'snapshot' cover?

It is a dynamic picture of partnerships, and identifies progress over the last year, taking into account: different pressures affecting partnerships; the extent to which partnership working has become routine practice; and the impact of partnerships on services and the lives of vulnerable people. Specifically, the paper covers:

- the match between central policy and local vision
- the impact of wider policies on health and social care partnerships
- the extent of a cultural shift and how far partnership working pervades all levels within health and social care organisations

- emerging models and approaches to partnerships
- outcomes for service users and carers.

Central 'push' or local 'pull'?

This section summarises the key drivers for partnerships and the progress that has been made. Problems and growing tensions between Government aspirations and local priorities are discussed.

Positive drivers for partnerships

We are in the midst of a major cultural shift where there is a move away from traditional models of service provision to working together in different ways across the whole system of services. Although the extent of change is varied across the country, and across different services and professional spheres, partnership working is no longer regarded as an optional extra but now takes centre stage. It is not whether partnership working is to be adopted, but rather how to carry it out. This change has been driven on several fronts.

The cultural shift has been supported by an increasing recognition of citizens' rights to better-quality services. Changing public expectations have encouraged thinking outside of traditional organisational and professional boxes, and promoted different types of delivery at the frontline. New partnerships are developing across statutory, voluntary, not-for-profit and private sectors to improve services.

The Government has reacted to people's impatience and frustration with inflexible and uncoordinated services, and has seen partnerships as key to resolving problems within the service system and with the quality of public services.[2] Central policy has thus driven forward partnership working using incentives and sanctions to achieve change:

- Legal obstacles to joint working between health and social services have been removed, and special grants made available to foster partnership working.
- Policy has increasingly shifted towards mandatory arrangements: the Health Act 1999 places a duty of partnership between health bodies and councils.
- The Government has been encouraging partnerships other than those between health and social care, through, for example, the Local Government Act 2000 (which calls for partnerships between the council, public, voluntary, community and private sectors to improve the economic, social and environmental well-being of their areas) and its policy on public-private partnerships throughout public services. Local Strategic Partnerships are seen as the overarching local framework within which more specific local partnerships can operate, such as those to implement national service frameworks.[3]

There is considerable support for partnership working from statutory, voluntary and independent sectors, particularly as there is increasing recognition of the interdependence between partners in improving services and the importance of whole systems approaches. However, there are several faultlines opening up in the current picture as Government 'push' meets the different 'pull' and pressures at local level.

Different objectives for partnerships

One of the underlying tensions is around the different objectives for partnership working. Initial drives for partnerships, particularly those concerned with broader agendas around public health

and regeneration, have been largely overtaken by Government priorities to solve pressures in the service system to primarily benefit acute health services. Government policy can appear to be increasingly less concerned about promoting the coordination of better housing, primary health, social care and other community services to improve outcomes for users and carers, and to have become fixated on working together only to reduce emergency admissions and delayed discharges from hospitals. Indeed, partnerships are presented as the solution to ills affecting acute health services. Ironically, there is some evidence that acute trusts are only occasionally involved in local partnerships using the flexibilities. Where they are, they may be more likely to be involved in mental health partnerships, which is not where the acute bed-blocking problems arise. There are fears that this political agenda is distorting partnership working and diverting attention away from a range of other activities also needed to directly improve outcomes for users and carers.

There is a relentless push from the centre to show rapid and visible changes in services. Tighter performance monitoring, star ratings and league tables – along with measurable changes, for example, of more intermediate care 'beds', and visible new structures such as care trusts – may have unintended outcomes. Increasing beds for intermediate care runs risks of tying up resources in institutions rather than providing rehabilitation at home, which is most older people's preference, and providing, at the worst, 'holding' – rather than effective – rehabilitation opportunities. Performance monitoring and star ratings need to be more broadly based if they are to support radical steps on the ground to move beyond the imperative to reduce pressures on acute health services. Also audit and performance management systems are not fully 'joined-up' which, at best, involves duplication and, at worst, undermines local attempts at partnerships.

Care trusts and partnerships

The debate around care trusts has muddied the waters of partnership working. Initial arguments in favour of this approach have been forcefully countered. For example, claims these mergers will end dual value and organisational systems have been challenged by problems in resolving accountabilities and structures and difficulties in addressing cultural differences.[4] There are fears that these new structures may be recreating the silos of the past and a new set of boundaries that prevent the delivery of better integrated care. Some have argued care trusts are now an outdated solution.[5] 'The issue is not about how we develop organisations, it is about how we develop the delivery of services. There may be a variety of service structures to support that.'[6]

There appears to have been some change in emphasis from the centre about care trusts over the last six months and some toning down of the original pressure to create care trusts as a solution to those failing to work in partnership. While there may be merits in care trusts in some situations, there are dangers that the continued perceived threat or incentives to adopt national models risk 'shotgun marriages', rather than sustainable joint-working relationships and locally-tuned approaches to partnership working.

Changing partners and financial pressures

There are not only tensions between Government vision and local priorities, but progress on partnerships continues to be challenged by organisational change within the NHS and reconfigurations in local government. At the same time, major budget pressures in both health and social services undermine developing partnerships, despite the opportunities offered through the use of flexibilities to solve some of the resource issues.

Organisational change within the NHS

Changes within the NHS are altering previous balances of power. Primary care trusts are desperately short of capacity to deliver on partnerships because they spend energy, time and limited staff resources setting up their organisations and tackling a huge agenda, including pressures of waiting lists and drug expenditure. However, primary care organisations are gradually beginning to gain more experience and confidence in participating in wider alliances, particularly in health improvement activities, while acute health services are often notable by their absence in partnerships. This divide may be exacerbated if 'successful' hospitals gain autonomy to commission local services at the same time as primary care trusts use their considerable budget to influence local service provision. The picture is fluid and varied across the country. In some areas, there are signs of limited progress in joint working between primary care trusts and acute trusts.[7]

While there are a number of good examples of innovative partnerships between the NHS and social services, for example, in intermediate care developments and strategy groups implementing mental health and older people's National Service Frameworks, all of these changes within the NHS make it more difficult for local authorities to forge stable joint-working relationships with their health colleagues, which then disrupts local partnership networks.

Changes within local government

At the same time as partners within health services are changing, local government is tackling its own Cabinet-style reorganisation and seeing the emergence of a range of new partners. New players such as social landlords, Sure Start and Connexions call for the development of new working relationships within local government. All of this is taking place as local authorities feel they are being pruned back and losing their ability to support coordinated planning across the locality. They are having to adjust to different strategic partnerships where power is being exercised in different ways.

The national picture is far from static or consistent as authorities face different local political pressures and juggle these with a vast list of priorities set by central government. Authorities are being challenged to find corporate responses to Government and local priorities, rather than scapegoating particular departments.

Changes affecting voluntary and private partners

Voluntary, private and independent partners are also affected by changing power relationships. In some areas, voluntary organisations are not always clear about their role within the new partnerships developing between health and local government. They can be caught between alliances that may compromise their position as lobbyists yet are essential to their survival because of funding.

Private and independent organisations have an even more ambivalent role in partnerships. Although Government promotes their inclusion, the NHS and local government have different views about private sector partners, and very different experience in working with them. Local government has considerable experience negotiating and working with private providers, while the NHS is guarded about bringing them into the mainstream. Local government experience in negotiating with private providers will be particularly important to primary care groups and trusts in purchasing intermediate care services from nursing and residential homes and in calls for effective partnerships in commissioning.

Financial pressures on partnerships

Financial clout is at the heart of relationships and the exercise of power between partners. There are reports that financial pressures on both health and social services are affecting partnerships and causing partners to be reluctant to engage in joint ventures, particularly where there are fears of picking up the other partner's deficit or losing financial manoeuvrability. Many primary care trusts, for instance, are wary of local authorities that are having to cut back to avoid a serious overspend. Local authorities face major challenges in meeting all their responsibilities, not least to stabilise their children's budget. Recognition that part of the overspend in social services is due to NHS pressures has been acknowledged in recent Government funding awarded to local authorities, but if the primary purpose is to save acute health services, partnership working feels very fragile.

There are few signs of financial pressures lessening in the short to medium term and, indeed, they may intensify, especially for the NHS in which the Government has put so much store. At the least sign of difficulty, there is every incentive for partners to off-load responsibilities or to retreat from partnership working.

Extent of cultural change

There continues to be a gap between the vision of partnership working and the reality of practice on the ground, and there is some way to go before achieving effective collaboration in frontline services. Shared strategies will count for little unless there is significant change in frontline professional 'worlds' and inter-professional relationships.

Changes in frontline working

Winter pressures funding and intermediate care developments have helped to promote mixed teams of health and social care staff working together. However, these new and promising developments (including the 'virtual teams', for example, community nurses and homecarers who are not co-located but have agreed responsibilities and roles) are often disconnected from other mainstream activity. It is not clear how far these new teams and approaches have influenced the culture across different tranches of staff.

The development of clinical networks, where there are groups of health professionals and organisations working in a coordinated way across professional and organisational boundaries, may also support cultural change, and stimulate creativity and innovation focusing on the needs of patients.[8] It is yet to be seen how these networks will engage with social care and other partnerships.

Research shows it cannot be assumed that if inter-agency partnership policies, processes and structures are established, then frontline partnerships between a range of traditionally separate professions will simply fall into place.[9] The empirical literature on professional team working has mixed evidence of success. Professional preciousness and tribal hierarchies impede partnership working; staff may be unwilling to trust each other's assessments and cooperate within teams. Professional schisms within the NHS can be as damaging as those cutting across medical, nursing and social care.

Middle managers as change agents

The extent of cultural shift is not only questionable at the frontline. Some middle managers are caught between fulfilling a corporate role with explicit procedures and responsibilities, and working in new, flexible ways with more apparent risks. They are often expected to undertake both the 'day' job and the role of change management, as well as cope with shared loyalties to two different organisations. Most middle managers are given little backing, training or time to work with new partnerships, and tackle conceptual and practical problems. These will include major headaches around negotiating pay and work conditions, resolving professional issues and arranging accountable joint budgets and joint information systems. Much of their work goes unrecognised as performance measures are largely aligned to traditional roles, not those within partnerships, and there are few explicit rewards for partnership working.

There is some evidence that making partnerships work relies heavily on 'reticulists' or 'network entrepreneurs'. One manager holding a joint post claims the added value of a job that straddles the boundaries is 'the ability to make the processes visible and to bring into view not only the things that need to be done to complete the job but to be able to show the way in which things are done by different organisations … new pathways are hacked through the jungle that can be more easily trodden a second time'.[10] Evidence about the specific skills needed for this network entrepreneur role, what structures might promote or impede their activity, and how this type of activity can be positively supported, need to be fed into leadership development and selection programmes.

Shared learning initiatives and new joint leadership programmes for middle and senior managers are beginning to take place but there is some way to go to provide the incentive and develop capacity of those with responsibility to deliver partnership working at the frontline.

Challenges to supporting cultural change

Commissioning practice is variable across health and social services, each with a history of taking very different approaches, and much remains to be done to build the capacity of commissioning in partnership.[11] Many questions remain about the role and degree of autonomy that will be awarded to 'successful' hospitals, and their relationships with PCTs as commissioners. Transferring learning from leading edge PCTs to others will also be an important component of change.

Integrated support systems will also be key to delivering integrated care solutions. Separate information strategies for the NHS and social care, and separate complaints systems need to be brought together to support change.

Pressing staff shortages within both the NHS and social services challenge moves to support cultural change. A recent inquiry into care and support workers underlines the looming crisis because of underinvestment.[12] It is yet to be seen whether current campaigns to attract more social workers, and medical and nursing staff prove to be successful.

The role of elected members and non-executives in supporting cultural change is crucial and calls for them to be fully conversant with policy, and willing to support new ways of working. This is at a time when they are taking on new roles and responsibilities, including, for example, the new scrutiny role of councillors. If used constructively, the scrutiny system could offer opportunities to democratise health and make partnership working more meaningful. However, there are concerns that in the absence of established and good partnership working, hearings could become adversarial and set back positive joint working arrangements.[13]

Emerging models of integrated care

Different models of partnership working are emerging for different care groups, responding to central drives and resources. There is no one model of partnership working and, although partnerships need to relate to the whole life of a person in every instance, different lead roles are being taken by the partner agencies, in some cases reflecting rather different commitments.

Models of integrated provision are emerging mostly for services to people with mental health problems or learning disabilities. Different schemes are developing for older people, such as reablement services, integrated home care teams and rapid response teams, which have been encouraged by intermediate care and winter pressures funding. Partnership models are most underdeveloped for children's services where the needs of different groups of children, for example, for child protection, family support and special needs, create particular problems in bringing together a large number of agencies and approaches.

Each model is responding to different policy tensions. For example, older people and adult services face problems with charging policies for care services and free health services; learning disabilities services have to address the tension between principles of an 'ordinary life' and specialist support.

There are reports, albeit contentious, that in some partnerships for particular care groups, one of the partners may be less than willing to play an active role and gladly passes on responsibility to the other. These 'sloping shoulder' partners appear to be most evident in joint arrangements for people with mental health problems or learning disabilities where one agency offers a more natural lead and the other is only too relieved to step back. Local authorities talk of 'not letting health colleagues off the hook' in learning disability services, while in mental health services some local authorities are said to be 'sloping off'.

As new partnerships develop, there are concerns that new boundaries are being created, particularly where structural arrangements are set up. There are dangers, for example, in children's services, where the primary partnership is between education and social services, that new boundaries may be created for children with disabilities who need specific health care input. Similarly in older people's services, new boundaries may be created for older people with mental health problems where there is a separate mental health care trust and a care trust for services to older people. The creation of care trusts for services to people with learning disabilities may be problematic for engaging housing, leisure, and education and employment services, which are essential to delivering national policy.

Further investigation is needed into the influence of disabled people's experiences of running services or using direct payments on integrated service models. These may prompt very different models where disabled people coordinate services, including some health services, through the use of direct payments and other sources of funding. The increasing influence of older people and their use of direct payments may similarly press for approaches that they can control directly.

Impact on users and carers

As yet there is little evidence about the impact of new partnerships on the lives of service users and carers. The emphasis has been on creating and developing partnerships. This has been borne out by an interim report on the use of flexibilities, which showed most sites identified achievements relating to the process of partnership working itself, rather than any product of that relationship.[14]

It is also reported that implementing the flexibilities in some areas has prompted a renewed commitment to involving users.

Evaluating partnerships and their outcomes

Evaluation of progress and outcomes of partnership working is crucial both for local stakeholders as well as for national and regional monitoring. There are two distinct parts to evaluation: to assess the process of joint working or 'health' of the partnership; and to evaluate the outcomes for service users, services, the organisations involved and the whole system.

There are a number of tools which have been developed to assess the process or health of partnerships (for example, the Partnership Assessment Tool;[15] Partnership Readiness Framework;[16] Audit Commission Effective Partnership Working Checklist for Action[17]). These address key indicators of successful partnerships and include, for example, from the Nuffield Institute's Partnership Assessment Tool:

- recognition and acceptance of the need for partnership
- clarity and realism of purpose where there is shared vision, joint aims and a focus of partnership effort on areas of likely success
- senior commitment and ownership of partnership across and within partner organisations
- trust which is maintained by according equal status to all partners and fairness in distributing gains , and trust which can be sustained when faced with external problems
- clear, robust partnership arrangements where there is transparency in the financial and other resources brought to the partnership, clarity about responsibilities, time-limited and task-orientated structures and a prime focus on process and outcomes not structure and inputs
- agreed success criteria and effective arrangements to monitor and review service aims and partnership process.

Tools for assessing the outcomes of partnerships are less developed. Evaluation needs to consider the impact of partnerships on the lives of service users and their carers; the changes in services as a result of the partnership; the outcomes for the organisations involved and any impact across the local service system. The nature of partnership working and its focus on addressing complex and difficult issues thus requires a pluralistic approach to evaluation.

One framework offered[18] suggests a number of key criteria for evaluating partnerships on which different stakeholders will take their own perspective. These criteria include: the effectiveness of partnerships – how far these have achieved their objectives; equity – the impact of a new partnership development on other client groups; and efficiency – the ratio of benefits to costs. Dissonant expectations and viewpoints of the partner organisations and other key stakeholders on each of the criteria make evaluation a complex activity. For example, a criterion of acceptability would include evaluating the acceptability to users (and non-users) of their involvement in partnerships, their views on the quality of integrated services and the way in which services are delivered. The criterion of acceptability would also include the perspective of local authority councillors which, for example, may rest on having a visible local authority presence in a newly integrated service. In addition, acceptability to staff may include their views about perceived threats to their job security or employment conditions.

It is unclear how far local agencies and national and regional bodies are routinely assessing partnerships and where they are if this goes beyond a rather superficial appraisal. For instance, recent difficulties in Birmingham, where delayed discharges from hospital reached record high levels, indicated serious underlying problems in NHS and local authority partnership working.

These problems were not identified in reviews. It appears evaluation of the state of partnership working tends to be used at the time of major problems rather than as a way of systematically reviewing progress.

Much remains to be learnt about the effectiveness of partnerships and to bring together local experience, different strands of research, feedback from service users and carers and information from national and regional inspection and monitoring.

Conclusion and recommendations

What has changed in partnerships over the last year?

On the positive side, partnership working between health and social services continues to show signs of progress. This is the view of our expert group, which is supported by other research and review reports. An interim report on the evaluation of the use of Health Act flexibilities showed a generally positive view of partnership working,[19] and only a minority of partnerships appeared to have persistent problems. The joint review team judged partnership arrangements to be maturing across the country.[20] The national tracker survey found two thirds of primary care groups and trusts were involved in or planning partnership projects using flexibilities – an increase from the 13 per cent recorded in 1999.[21] At the frontline, a survey of social services staff undertaking assessment and care planning for older people found 68 per cent said general arrangements for working with the NHS were good or very good.[22]

Less encouraging, but unsurprisingly, organisational disruption and embedding new ways of working at every level of partner organisations, and throughout a range of professions, continue to present major challenges to implementing policy. Partnerships extending beyond health and social services appear equally fragile and varied.

In addition to these challenges, there are continuing difficulties in resolving essential 'nuts and bolts' issues. These include problems relating to staff issues – such as terms and conditions, pensions, and accountabilities. Secondly, there are information management and technology issues such as difficulties in linking up separate national IT strategies for health and social care, personal information sharing, and social care access to NHS Net.

What does appear to have changed is the intensity of Government pressure to show results and to shift the emphasis from improving the health and well-being of vulnerable people to a more narrow preoccupation with solving problems in acute health services. This is particularly damaging for some of the innovative partnerships which have developed between social care, community health services and primary care, and who see their shared agenda high-jacked to serve the interests of the acute sector, who are often the least concerned with partnerships. The Government is pushing an agenda for change and expecting demonstrable outputs within months. Any cycle of change is more likely to take years.

While there is an urgency to improve and integrate services, pressures on all the partners and the fragility of many partnerships suggest the need for increased support and incentives. The danger is that failing to provide this – and pushing for change in ways not yet proven – could set back partnership working and, ultimately, improved services and outcomes for vulnerable people and their carers.

Recommendations for supporting partnerships

1. There is widespread support for Government policy on partnership working, integrated services and quality user-centred services but time is needed to deliver this locally and any further initiatives compelling partnerships or new structural arrangements should be resisted. Local partners need greater freedom to identify and manage their own partnership objectives beyond solving problems in the acute health sector. In return local authorities and their health partners will need to show evidence of progress in establishing sustainable partnerships, improved services and the impact on the quality of people's lives.

2. As part of demonstrating progress in partnerships and their outcomes, ongoing work to review performance assessment needs to check:

- whether current indicators are appropriate for the outcomes partnerships seek to achieve
- where efforts are being duplicated by partners to fulfil the separate monitoring systems
- how this framework can be used for purposeful monitoring of partnership working through joint reviews and joint monitoring.

3. Serious consideration should be paid to avoid building in penalties which might damage partnership working. Instead, the emphasis should be on providing incentives to partnership working. One possibility may be offered through Local Public Service Agreements where a local authority's commitment to deliver specific improvements in performance may be in partnership with health. As part of the agreement Government would commit to reward these joint improvements. This approach could provide both a financial incentive in the form of reward grants as well as support a focus on outcomes where these agreements concentrate on results rather than processes.

4. Under resourcing of social services seriously jeopardises the partnership agenda, particularly where budgets are skewed by the demands of children's services. Funding for social care needs to be increased to a level commensurate with the workload expected and to allow for investment in early preventive services.

5. Further organisational changes in any of the partner organisations should be avoided for at least the next two to three years and proposals resisted to reorganise in order to improve delivery of services to families and children. This will allow for the establishment of PCTs and other developments to modernise services so that strong local networks and relationships between the key players have every opportunity to mature.

6. Change needs to be resourced in its own right so that staff are fully trained and there are dedicated staff to provide the leadership needed within and across the partner organisations. Investment in leadership development for middle managers is particularly important. Partnership working also needs to be included in national professional training courses.

7. Further central support should be given to help solve problems in harmonising terms and conditions for staff and information management and technology systems across health and social care.

8. User empowerment is an important driver for cultural change and support should be given to progressing local involvement of service users, carers, patients and the public in ways which cuts across service boundaries and engages those people who are often excluded. Financial and other support should be provided to ensure vulnerable people are properly engaged in partnerships between the NHS and local government, in steering developments and monitoring and evaluating progress.

9. In order to assess the benefits for service users and their carers it will be crucial to bring together learning from the field and recent and ongoing research which illuminates what is happening and the outcomes of partnerships.

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Appendix 1

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