



**Improving Population Health in Glasgow:  
Managing Partnerships for Health Improvement (Phase I<sup>1</sup>)**

**Final Report**

Dr Moira Fischbacher  
Miss Jane Mackinnon  
Dr Judy Pate  
Professor Phil Beaumont

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<sup>1</sup> This report marks the closure of the project funded in October 2005 by the Glasgow Centre for Population Health. Further funding has since been awarded to extend the project and as a result, the work conducted so far and reported here is being referred to as Phase I.

## **Executive Summary**

The research reported here set out to evaluate the development of East CHCP in terms of the principles of successful partnership working, and the measures of success that have been identified from previous studies of partnership working. Particular attention was given to the clarity and acceptance of partnership working and its associated arrangements, the progress made in different service areas within the CHCP, the nature and development of inter-agency trust, and the way in which organisational and professional identity was developing / changing in light of the unified CHCP structure.

The research involved 2 years of quantitative and qualitative fieldwork where, after a CHCP-wide survey, members of the team interviewed and observed staff at all levels of the CHCP so as to gain an in-depth understanding of the processes of partnership development and partnership working, inter-personal dynamics and individuals views of the CHCPs achievements in relation to the principles and measures of successful partnership working. Focused case study work on four service areas within the CHCP was also undertaken in order to explore further some of these issues across different service areas where different stages of integration between health and social work staff exist.

There are two important contextual factors for the findings presented within this report. The first is the high level of entrenched social and health inequalities that exist in the East of Glasgow which the CHCP is faced with as a starting point for its efforts to improve health and wellbeing. The second is that the CHCP was established with the intention of ensuring a year of relative stability at the outset to enable structures, processes and relationships to form and build before implementing changes in CHCP services. The findings should therefore be read with this in mind as they reflect the progress that the East CHCP has made within these challenging circumstances.

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 tackling complex problems. Whether the vision could be realised between such culturally different organisations, characterised by sub-cultures of strongly formed professional groups, was, however, viewed with some scepticism. There were mixed messages about the success of partnership working and a sense that staff were 'waiting to be convinced' that their efforts would pay off. Significant issues were raised in relation to the capacity for change and partnership working – although willingness to change was often in no

doubt – and a particular issue for the CHCP is in relation to the level of trust in senior management. Staff display high levels of confidence in their peers, but have yet to witness how senior management deliver against expectations – particularly in relation to the views expressed during staff consultations. The findings highlight a considerable opportunity for management to take the development agenda forward, but place an onus on the openness of communication and the identification of some clear early wins if partnership working is to be considered worthwhile in the eyes of CHCP staff. Particular aspects highlighted in the report are 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 to ensure that issues of professional identity are addressed in such a way as the perceived ‘erosion’ of professional identity is not an ongoing barrier to change.

Continual mention is also made of many positive characteristics that the East CHCP has demonstrated: willingness to change, openness to scrutiny, reflexivity (demonstrated not least by the access given for this research), and a resilience in the face of the demands made upon staff by the inevitable process of ongoing change.

Overall, the report highlights a number of issues that senior, middle and operational managers can use as a basis for discussion and organisational development activities – some of which have already been discussed with the CHCP prior to the publication of this report.

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# 1 Introduction to the Report

This report presents the findings from research exploring the development of Community Health and Care Partnerships as the new vehicle for delivering health and social care services in Glasgow City. The research forms one strand of a programme of work developed by the Glasgow Centre for Population Health (GCPH) which aims to “maximise the impact of Community Health Partnerships on health improvement and health inequalities by generating, reviewing and supporting the implementation of evidence, and building capacity for understanding and action” ([www.gcph.co.uk](http://www.gcph.co.uk)).

This GCPH-funded project *Improving Population Health in Glasgow: Managing Partnerships for Health Improvement* was initially funded for the period 1<sup>st</sup> October 2005 until 30<sup>th</sup> September 2007. The project team comprises Ms Jane Mackinnon (full time Research Fellow), Dr Moira Fischbacher (Principal Investigator), Dr Judy Pate (Senior Lecturer and co-applicant) and Professor Phil Beaumont (co-applicant), all of the Department of Management, University of Glasgow. Prior to the end of the project, the team were awarded a further 15-months’ funding to extend the work. This report therefore serves as a Final Report for Phase I of that project.

The report has been written with an intended audience of East Glasgow CHCP, the GCPH Board, our Research Manager (Pauline Craig), and GCPH members / associated organisations. As such, we have focussed here on providing discussion in relation to project objectives/themes and the East CHCP as a whole, analysis according to various levels within the organisation, and discussion in relation to 4 specific case studies. We believe this approach will provide both an holistic and a detailed perspective on the issues raised during the work that are of particular salience to the GCPH, its members and the East CHCP.

## 2 Context and Background

During recent years tackling inequalities and improving health have become growing priorities for the Scottish Executive (Scottish Office, 1997; Scottish Executive, 1999). The white paper *Towards a Healthier Scotland* recognised the impact of life circumstances on health and the relationship with health inequalities and highlighted the need for public health policies to tackle these wider determinants of health (Scottish Executive, 1999). In 2002, with the release of their spending proposals (Scottish Executive, 2002a) and *Closing the Opportunity Gap* (Scottish Executive, 2002b) the Scottish Executive demonstrated the high priority they placed on tackling inequalities across all aspects of society, and acknowledged the links between the root causes of inequalities and the subsequent impact on the health and well-being of the population. Health and social care organisations are therefore a key intervening variable between policy makers seeking to improve population health, and the population at whom such policies are directed.

As policies have developed, partnerships as a means of addressing inequalities and improving population health have become the preferred organisational model. Partnerships are seen as the most appropriate mechanism for coordinating and improving health and social service delivery, as they offer the potential for bringing together disconnected sources of expertise and combining complementary perspectives and resources to improve health services (Hudson and Hardy, 1999; Laing et al, 2002). This move towards collaborative models is evident in a number of policies in recent years. *Modernising Social Services* (Department of Health, 1998) engaged with the move towards flexible partnership working across health and social service boundaries. Following this, the *Health Act* of 1999 promoted closer working between different parts of the NHS but also between the NHS and Local Authorities (LAs). In Scotland for instance, the *Joint Futures* programme was established to promote greater cooperation between the NHS and social services. Subsequent policies sought to continue this emphasis on strengthening links between the NHS and LA's in order to develop more efficient and accessible community services (Scottish Executive, 2000). The *Community Care and Health Act* of 2002 further promoted joint working by enabling an expansion of joint resourcing and management of community services between the NHS and LAs.

Currently, health and social care organisations' centrality to improving health is evident in policy documents where continual mention is made of the importance of improving integration, enhancing service delivery and undertaking joint planning as the basis for supporting communities, involving the public and ultimately improving health (see for example *Partnership for Care*, *Towards a Healthier Scotland*, and *Improving Health in Scotland: The Challenge*). The

2003 white paper on health, *Partnership for Care* (Scottish Executive, 2003a) highlights the value of partnership working in the delivery of services to the population, and outlines the Government's commitment to improving partnership working. Furthermore, *Improving Health in Scotland: The Challenge* (Scottish Executive, 2003b) emphasises the importance of partnership working at all levels as a vehicle for successful health promotion.

Recent Scottish health and social policy has been directed towards creating collaborative, inter-agency, planning processes and organisational structures that reinforce a local planning perspective with locally sensitive solutions, whilst taking an overall population perspective on tackling inequalities. The primary organisational means for achieving these objectives and addressing the Scottish Executive's priorities has been the creation of Community Health Partnerships (CHPs).

## Community Health Partnerships

Initially introduced in *Partnership for Care* (Scottish Executive, 2003a), and reaffirmed in the *Partnership Agreement* (Scottish Executive, 2003c), CHPs represent a very specific investment and belief in the value and contribution of inter-agency partnerships as a means of achieving health improvement. These new partnerships will build upon the collaborative ethos and mechanisms of earlier structures and partnerships, in particular the Local Health Care Cooperatives.

*It is intended that CHPs will create better results for the communities they serve by being aligned with local authority counterparts and by playing an effective role in planning and delivering local services.*

Partnerships for Care (2003a)

In 2004 all Health Boards were required to establish either a CHP for the area, or two or more CHPs for districts that include the whole area of the Health Board (SEHD, 2004). Underpinned by the Local Government in Scotland Act (Scottish Executive, 2004), Local Authorities are expected to lead collaborative Community Planning processes within the CHP structures. They, along with NHS and other agencies within the partnerships, are also to ensure that the health improving potential of Community Plans, Social Inclusion Partnership, Healthy Living Centres and other community-based initiatives is optimised (Scottish Executive, 2003c). In addition to these inter-agency partnerships, the NHS, LAs and community and voluntary sectors are

expected to work together to implement approaches which engage patients and community members in health improvement under the CHP umbrella.

Full details of the national aims and objectives of CHPs can be found in the CHP Statutory Guidance (SEHD, 2004). A summary of the key aims presented in *Partnership for Care*<sup>2</sup> state that CHPs would:

- ensure patients, carers and the full range of health care professionals are involved;
- establish a substantive partnership with local authority services (e.g. social work, housing, education and regeneration);
- have greater responsibility and influence in the deployment of Health Board resources;
- play a central role in service redesign locally;
- focus on integrating primary and specialist health services at local level; and
- play a pivotal role in delivering health improvement for their local communities.

(Scottish Executive, 2003a)

More recently *Building a Health Service Fit for the Future* (NHS Scotland, 2005) emphasised the importance of CHPs in improving local coordination and delivery of services, although this has tended to be addressed more in terms of links between primary and secondary care rather than between the NHS and social work services. However, some areas, such as Glasgow City, have developed a model which places greater emphasis on the integration of the NHS and the City Council social work services. This has been done in an effort to drive forward a joint NHS and social work agenda for the improvement of population health and well-being (GGNHSB and GCC, 2005).

### **The Glasgow City Integrated Model**

Greater Glasgow NHS Board<sup>3</sup> (GGNHSB) and Glasgow City Council (GCC) responded to CHP policy by seeking to integrate NHS and Social Work more fully than CHPs elsewhere. This strategy is reflected in the renaming of the 5 new Glasgow City CHP organisations to Community Health **and Care** Partnerships (CHCPs), a symbolic move designed to represent

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<sup>2</sup> These aims are adapted for each CHP, and local objectives and priorities are set out in the individual Schemes of Establishment (<http://www.show.scot.nhs.uk/sehd/chp/>).

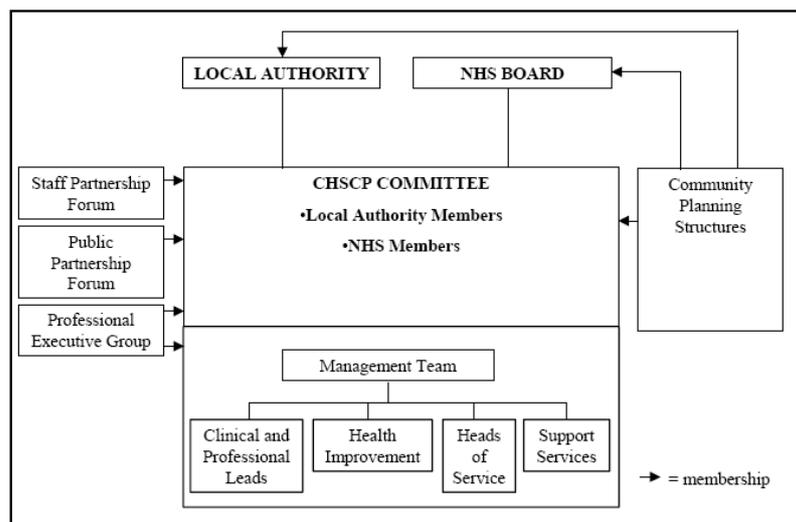
<sup>3</sup> At the time of establishment the NHS was represented by Greater Glasgow NHS Board, now Greater Glasgow and Clyde NHS Board.

inclusion of the ethos of both NHS and Social Work organisations. The CHCPs will bring together NHS and LA responsibilities with the aim of maximising the ability to improve outcomes for service users. Initial priorities for the development of the CHCPs further highlight the integration of health and social care services, including a clear programme to tackle health and social inequalities; continued implementation of the new Practice Team model of Social Care Services and realising the gains for service users of fully integrated local services (GGNHSB and GCC, 2005).

What is significant here is that whereas there have been joint working arrangements between the NHS and Social Work services for a number of years, the level of integration planned through the development of CHCPs has not previously been experienced locally. Joint working was previously restricted to pooled budgeting, lead commissioning and joint provision of services. CHCPs, however, go further to create a single, integrated management structure and accountability framework yet retain clear lines of accountability for statutory functions, resources and employment issues within the parent organisations, Greater Glasgow & Clyde NHS Board and Glasgow City Council.

In Glasgow City, the CHCP functions are governed within the management structure shown in Figure 1<sup>4</sup>.

**Fig 1: The Governance Arrangements**



(Source: Scheme of Establishment for Glasgow City CHCPs, 2005)

<sup>4</sup> The 'CHSCP' (Community Health & Social Care Partnerships) shown in figure 1 represents the former name given to CHCPs.

Within the management structure a number of advisory groups have a role in shaping CHCP policy and practice. Each of the CHCP management teams are led by a Director appointed jointly by the NHS Board and Glasgow City Council (GGNHSB and GCC, 2005). Members of the management team within each CHCP were also to be joint appointments and may be employed by either organisation. The main exception is the Heads of Children's Services who must be a Council employee in order to meet statutory accountability requirements. In addition there was a requirement for four of the five Heads of Mental Health to be NHS employees with one employed by the Council in order to reflect the balance of statutory responsibilities whilst ensuring a clear social work line of accountability (ibid).

The Professional Executive Group (PEG) has been established with the aim of representing the views of professional groups within the planning and development structures of the CHCP. This group, along with the Staff Partnership Forum, aims to provide staff with a voice within the partnership development. Similarly, the Public Partnership Forum aims to provide a voice for service users, carers, and members of the public served by the CHCP.

The purpose of the Committee is "to set budgets within the CHSCP allocation, to take a strategic overview of the CHSCP's activities, priorities and objectives and to hold to account the management team for the delivery of the CHSCPs annual plan, which that team should develop, in partnership with the PEG"<sup>5</sup> (GGNHSB and GCC, 2005). The CHCP Committees were to be established with a balance between health and local authority members, to reflect a partnership approach, and would include key stakeholders from the PEG, staff and public partnership forums, and the voluntary sector.

It is evident from this section that CHCPs have an ethos of partnership at their core. Before the research methodology and findings are presented the following section provides the reader with some further context for CHCPs and the current research in relation to partnerships and integration.

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<sup>5</sup> The 'CHSCP' (Community Health & *Social* Care Partnerships) refers to the former name given to CHCPs.

## Understanding and Studying Partnerships

Within the policy and academic literature terms such as ‘partnership’, ‘joint working’, and ‘integration’ are often used interchangeably and it is therefore important to position CHCPs within this body of work.

As outlined earlier, recent social care and health policies have demonstrated increasing emphasis on the delivery of integrated services and care packages through the mechanism of partnerships and networks of practice. Traditionally, services are organised in two ways: vertically according to professional and policy domains; and horizontally according to governmental domains (Neis, 2006). The resulting fragmentation creates system inefficiencies, quality problems and poor experiences of services (Axelsson and Axelsson, 2006; Moore at al, 2007). The consequent difficulties to arise from this process are known as ‘integration problems’, such as duplications, gaps, inconsistencies and discontinuities in the provision of services (Axelsson and Axelsson, 2006). Hence, the need for integration is strengthened, and the fragmentation and resulting system inefficiencies have provided an incentive for a shift in policy and service development towards more integrated services that are responsive to individual needs. However, as Moore (2007) highlights, “the concepts are intuitively appealing, but the terms are not defined”. This is evident in many policy documents where the terms partnership, joined-up working, and integration are used frequently but with little explanation of substance in how to understand and then implement such concepts and models of working.

According to some authors, integration can be viewed as a continuum ranging from complete autonomy of departments or organisations right through to a merger (Eilbert and Lafronza, 2005; Axelsson and Axelsson, 2006). However, others do not consider full integration as a merger. For instance, Nocon states that “*models of integrated working can be located on a spectrum that ranges from limited collaboration on specific issues to full integration as represented by pooled resources and a single set of objectives*” (in Stewart et al, 2003, p336). In its fullest sense, integration could be considered to address each of the following functions:

- Administrative: co-ordination or consolidation of administrative functions and planning
- Organisational: horizontal and vertical networks, joint projects, mergers
- Funding: shared budgets, incentives, disincentives
- Service delivery: team-based services, integrated measures of quality and outcomes

- Clinical: shared knowledge and models of diagnosis, language, practices, standards, measures, and feedback

(Source: NHS Scotland, 2005)

The CHCP encompasses aspects of all these categories including integration of some administrative functions, organisational integration and integrated funding decisions at a local level. The new partnerships do not, however, go to the extent of a merger of organisations as the relationship and a level of central control is retained by the parent organisations. Eilbert and Lafronza (2005) present a partnership typology that is useful for considering the different degrees of integration seen within collaborative structures, and therefore within the context of CHCPs. Figure 2 highlights the different processes and structures that might be used to achieve varying degrees of integration. Although this model might not be applicable to all forms of partnership, it provides a useful framework for understanding the current research. In this case the CHCP model is the partnership structure which advocates a high level of integration, and a process of collaboration (i.e. joint problem solving, joint service delivery), rather than a loose cooperative or coordinating process that is more similar to joint planning structures seen in the past.

**Fig 2: Partnership Typology (Adapted from Eilbert and Lafronza, 2005)**

Process	Structure	Level of integration
<i>Independence</i>		<b>Less</b>
Networking	Roundtable	
Coordination	Task force	
Cooperation	Coalition	
Collaboration	Partnership	
<i>Full Integration</i>		<b>More</b>

This new form of partnership and the move towards integration clearly represents a significant change in working practice between the two parent organisations with different cultures, structures and philosophical approaches. Such inter-organisational and multi-disciplinary partnerships represent a means of governing the actions of multiple providers within a set of relationships that, though they may vary in their degree of formality, will necessarily be based to a large degree on trust. Indeed, it is trust and a shared culture that underpin partnership ties and which are central to the success of partnership arrangements (Jones et al., 1997). For

instance, trust is recognised as being an essential element of successful partnership working. In particular, it is positively associated with group cohesion (Podsakoff, 1996), effective decision making (Mishra and Morrisey, 1990), job satisfaction (Driscoll, 1978) and organisational performance (Mishra and Morrisey, 1990). In the context of partnerships, relational trust is also regarded as an alternative to calculative, contract-based inter-organisational relationships. Where trust exists between organisations, it is thought to be conducive to longer-term relationships and to create a climate in which partners go beyond what might be expected in a contractual relationship. As a result, an expectation grows of long-term collaboration that mitigates against the 'negative' effects of short-term thinking and opportunism.

In the partnership literature trust is often regarded as the 'glue' that binds partners together (Jones et al, 1997). Such a view provides a broad sense the function of trust in partnerships i.e. the need for strong relationships at a time of change and uncertainty. A key contribution of this project is to unpack the crucial concept of trust within a partnership context. Thus consideration needs to be given to the nature of trust, its development over time and the ways in which it might be manifested. In the same way, the notion of "a conducive institutional or social environment" (Dowling et al, 2004) also needs to be operationalised in some way, as it can embrace many and varied aspects of organisational life. Given the strong degree of professionalisation within health and social care organisations, a key dimension of the institutional environment is the professional ethos, hierarchical relationships between professions and the nature of professional boundaries.

Within all organisations there exist many groups and sub-groups with corresponding sub-cultures. Within highly professionalised organisations, the strength of identification with an occupational group is particularly strong as is the influence of organisational culture. Where two organisations (in this case the NHS and Social Work) are being brought together under one managerial structure, it becomes important to understand the effects of professional identity and organisational culture. Closely related to the issue of professional identity is the matter of professional line management. The new unified CHP structure introduces the potential for complex lines of management and accountability across organisations and professional groups. Although professional leads will be present within the structures for specific guidance and career progression, on a daily basis staff could be being managed by someone from the partner organisation with whom they might not identify. An important consideration for CHCPs will therefore be to gauge the implications of such changes might be to individuals, organisations and ultimately the end users.

The development of these intangible dimensions of trust and common cultural values, sits alongside debate about structures, accountability and resource allocation, as partnerships often challenge conventional resource flows, patterns of activity and relationships between occupational disciplines (Fischbacher and Francis, 1998; Goodwin, 2000). Managing partnerships thus necessarily involves a set of managerial competencies that reflect this new way of working such as negotiation skills, interpersonal skills, the ability to construct and manage multiple agendas, and to develop long-term relationships. Personality-traits and personal leadership styles also become more significant as partnerships suggest a move from leader-follower ways of working towards person to person interactions, where personal influence is often required to overcome structural barriers (Goodwin, 2000).

Addressing these issues in the context of CHPs is, however, problematic because of the significant difficulties in measuring changes in the health of the population and measuring changes within health-systems (Mitchell and Shortell 2000). Moreover, as Mitchell and Shortell go on to suggest, "Even if it were possible to measure population health status or system change accurately, it is difficult to demonstrate a cause-and-effect relation between those outcomes and CHP activities" (ibid, p259-260).

Although the difficulties articulated by Mitchell and Shortell (2000) are significant, it is possible to identify some means of assessing and thus identifying improvements in respect of partnership performance. Hudson et al (2000) suggest that all partnerships should be underpinned by six key principles if partnership success is to be achieved. These are:

- acknowledgement of the need for partnership;
- clarity and realism of the purpose of partnership;
- commitment and ownership of the partnership;
- the development and maintenance of trust;
- the establishment of clear and robust partnership arrangements; and
- monitoring, review and organisational learning.

A starting point, therefore, is to consider the extent to which these principles are being recognised within the partnership organisations in question. These principles also resonate closely with a series of indicators of partnership success developed by Dowling et al (2004). As illustrated in Figure 3, separate process and outcome measures allow for distinction to be made between organisational activities (processes) that underpin improvement in service outcomes.

**Figure 3: Partnership Success - Process and Outcome Measures**

<b>Process Success</b>	<b>Outcome Success</b>
Community engagement – measured by enthusiasm of partners towards the partnership	Improvements in access for service users – measured by early intervention and response times.
Agreement of partnership purpose and rationale – measured by degree to which aims and vision are shared and evidence of interdependency	Equity of distribution – assessed in terms of provision according to need within one service and between services.
Trust, reciprocity and respect between partners – measured by the confidence partners have in each other	Improved efficiency and effectiveness – indicated by service standards, costs and reduced duplication
Success in terms of financial climate, institutional and legal structures – measured in terms of whether the political / social environment is conducive to partnership working.	Improved staff and carer experiences – identified by changing work conditions, job satisfaction and quality of life for carers.
Satisfactory accountability arrangements – measures include lines of responsibility and appraisal arrangements	Improved health status/well-being by service users – measured by changes in services and changes in capacity to live independently.
Leadership and management – measured in terms of the quality of executive authority over strategic direction, and management towards the objectives.	

(Source: Developed from Dowling et al, 2004)

These processes can then be examined at various points in the evolution of the partnership such that these measures of partnerships success developed by Hudson et al and Dowling et al provide a useful framework for the development, analysis and interpretation of the current research.

It must be acknowledged that the CHCP operates in partnership with a large number and broad range of public and voluntary sector organisations. However, the purpose of this research was to explore the development of the CHCP and the relationship between the two core organisations. For the remainder of this report, '**partners**' should therefore be understood in terms of the formal and informal relationships between the two founding (parent) organisations, **Glasgow City Council** and **Greater Glasgow and Clyde NHS Board**.

## Setting the Scene for the East Glasgow CHCP area

In order to appreciate the full scale of the agenda faced by East Glasgow CHCP, and to set the background for the current organisational research findings, it is first important to understand the complex social context in which the partnership is delivering services. East Glasgow experiences a wide range of historically deep rooted, social problems that have resulted in poor health and quality of life for many residents in the area for some time. However, as the East CHCP Development Plan (2007-10) highlights, the picture is complex because despite overall figures concerning health and deprivation, "*there are many people and communities in the East End who do not perceive their health to be poor and lead fulfilling and enjoyable lives*". The health and social status of the area is of course influenced by both local and national changes in the economy and society as a whole so it is not a static picture but it is nonetheless true that in comparison to other areas of Glasgow and Scotland, the East Glasgow CHCP area experiences some of the most severe socio-economic and health problems. Some of the key statistics concerning the overall extent of social and health problems in East Glasgow are presented in Box 1.

### Box 1: Key facts and figures for East Glasgow CHCP Area

- An estimated total population estimate of 125,000 in 2004.
- Over 41% of the population live in the most deprived neighbourhoods in Scotland.
- Male life expectancy is 69.1 and female is 75.9 (6 years and 4 years respectively below the Scottish Average), with only 68.7% of 15 year old boys surviving to 65 (12% below Scottish average).
- More than half of the working age population is economically inactive (i.e. not in work) and only a limited number are moving into sustainable employment.
- Around 33% of children live in workless households (80% above Scottish Average).
- Over 37,000 people are classified as being in social grade E (state benefits, unemployed or in low paid jobs), around 45% above the Scottish average.
- The 2001 Census found that 36,361 lived in households where a member had a long term limiting illness (29% of all households in the area).
- Around 8% of babies are born with a low birth weight (38% above the Scottish average).
- Illness and death caused by smoking and addiction to alcohol and drugs are key issues for the CHCP to tackle with its partners. For instance, hospital admissions for heart disease (2000-02) were 38% above the Scottish average.

(Sources: East CHCP, 2006 and NHS Health Scotland, 2004)

While these statistics illustrate the extent of the socio-economic and health problems experienced by communities in East Glasgow, a number of strengths also exist within the area including a broad range of economic regeneration activities and housing developments, as well as a rich network of community and voluntary groups working towards improving the well-being and health of residents in the East (East CHCP 2006).

It is within this context the East CHCP management team has developed an agenda for the partnership that sets out their “contribution to improving the life chances for people living in the east Glasgow area” (East CHCP Development Plan, 2007). The remainder of the report presents some early views on the progress made in setting up the structures and systems that can enable this to happen.

### 3 Aims and Methodology

#### Research Aim and Objectives

The preceding sections have outlined some of the key policy and practice issues facing partnerships. In line with this literature, the overarching aim of the project was to address central considerations in the development of new organisational structures, i.e. whether they contribute to improving performance both in terms of service quality and ultimately in terms of population health. This was done by examining the development of the newly formed CHCPs, in particular East Glasgow CHCP. More specifically, the key objectives of the research were:

1. to improve our understanding of the underlying issues of partnership (inter-agency) management with a view to determining key, measures of effective partnership management that can enhance the performance of Glasgow's health services. Subjective perceptions of partnership members were combined with objective measures of effectiveness;
2. to examine the connection between local partnerships and the wider organisations within which they are embedded giving particular attention to issues of coordination and consistency, i.e. ensuring coherent strategy, policy and direction across the organisation. In short we were looking to identify the determinants of the effective management processes that are under the control of the partnership as opposed to the control of the larger organisational setting;
3. to explore in depth the precise nature and development of trust among partnership players (individuals and organisations); and
4. to examine the nature, basis and sustainability of trust between partners in the context of the successful delivery of service outcomes. In short, we were raising the possibility, which we wish to explore, of whether there is a trade-off relationship between a successful partnership process and successful delivery of health outcomes.

## Research Methods

These research objectives each require some understanding and examination of *processes* of partnership development, partnership management, formation of trust and views of trade-offs. As such, the research adopted a qualitative approach in the main. However, given research on partnerships and trust has a substantive literature, we were able to draw on previously validated questionnaires in order to develop a survey instrument that would allow a quantitative perspective on the work.

## Research Setting

After discussion with the Glasgow Centre for Population Health, and in line with the GCPH research strategy, it was agreed that the work would be conducted in East Glasgow where other research within the CHP workstream was also being conducted. Early discussions took place between Pauline Craig, Research Manager at GCPH and Mark Feinmann (then incoming) CHCP Director prior to the research team beginning the work. Although it was initially envisaged that this study would begin proper in October 2005, the start of the project fieldwork was necessarily postponed until a CHCP Director and full senior management team were in post. Before conducting any fieldwork the research team sought the approval of the CHCP Director and East Management Team (EMT).

## Ethical Approval

The research was conducted in accordance with the ethical procedures for the University of Glasgow, Glasgow City Council Social Work Services and the NHS Greater Glasgow (and Clyde) Local Research Ethics Committee (LREC). The LREC ethics application was granted on the condition that staff were not asked to identify their job title in the survey.

## Part A: Survey of CHCP Staff

A survey of all 1250<sup>6</sup> CHCP staff took place in July 2006, four months after the CHCP was formally created and the Director was in post.

### Survey Design

The survey sought staff views on prior experience and current expectations of partnership working, partnership capacity, trust in colleagues, line management and senior management as well as change management and early views of the CHCP role. The survey was designed to make use of validated scales on trust and identity (Clark and Payne, 1997; Mael and Ashforth, 1992) combined with questions adapted from partnership assessment tools used elsewhere (Center for the Advancement of Collaborative Strategies in Health, 2003; Hudson et al. 2000). This allowed us to capture organisational level issues alongside team and individual level issues.

The survey was divided into the following 5 sections:

1. *Views of the Employing Organisation*, which included attitudes towards work demands, expectations of and trust in colleagues, line managers and senior management;
2. *Professional and Organisational Identity*, i.e. the extent to which CHCP staff feel a strong association with their profession and the organisation who employs them;
3. *Experiences of Partnerships and Understanding of the CHCP*, which sought to ascertain whether staff had positive or negative views and experiences of partnership working at the outset, and whether they had an understanding of what the CHCP was and was expected to achieve;
4. *Partnership Capacity and Skills*, which considered whether staff had, or could readily develop appropriate skills and whether they considered those responsible for services and the CHCP to have appropriate skills;
5. *Expectations and Predisposition towards Change*, in terms of whether or not staff believe they can cope and others can deliver the change that's required for partnership working.

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<sup>6</sup> This is an approximate figure provided by the CHCP, allowing for vacancies, sickness and maternity absences at any one time. The figure does not include independent contractors of the CHCP.

These sections incorporated the project objectives and themes from the literature but in a structure that was accessible to respondents. For example, questions about trust were embedded within the section on views of the employing organisation and issues of commitment to partnership objectives (Hudson et al 2000) were embedded within sections 4 and 5<sup>7</sup>.

### **Survey Distribution**

The survey was intended to reach all 1250 CHCP staff. The internet survey tool Survey Monkey<sup>8</sup> was used to survey the views of the majority of staff. This approach was taken after extensive consultation with senior management in the CHCP as to what method of distribution would be most likely to yield a high response rate. Electronic surveys were thought to be more amenable to completion than paper-based ones. In order to maintain confidentiality the research team did not have access to staff email addresses. The electronic survey was distributed on their behalf with the help of CHCP resource managers. This was achieved by cascading the survey through the staff email system. However, as some staff did not have access to the Internet or to a computer, paper copies were also distributed to some staff groups and CHCP settings. A covering letter from the CHCP Director and the research team accompanied the survey.

### **Survey Responses**

In light of key contextual factors (e.g. potential gaps in email lists of the newly formed organisation, new staff joining), the survey was held open for 3 months; a longer period than anticipated, but necessary under the circumstances. During this time, a total of 389 surveys were completed, giving a **final response rate of 31%**. Ideally we would have hoped for a response rate of around 40% but as is often the case in survey research, analysis is necessarily based on a lower response rate, and 31% is considered to be acceptable, albeit with qualifications around the extent to which results can be generalised. However, despite some limitations, the results did provide an indication of attitudes amongst staff across the CHCP during the early stages of partnership development as responses included representation from social work and NHS staff from all service areas of the CHCP, included a range of job categories and professions, and covered a variety of roles (support, management, operational etc).

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<sup>7</sup> A full copy of the survey can be provided on request by contacting Jane Mackinnon by email at [J.Mackinnon@lbss.gla.ac.uk](mailto:J.Mackinnon@lbss.gla.ac.uk)

<sup>8</sup> The Survey Monkey website can be accessed at <http://www.surveymonkey.com>

### Characteristics of Survey Respondents

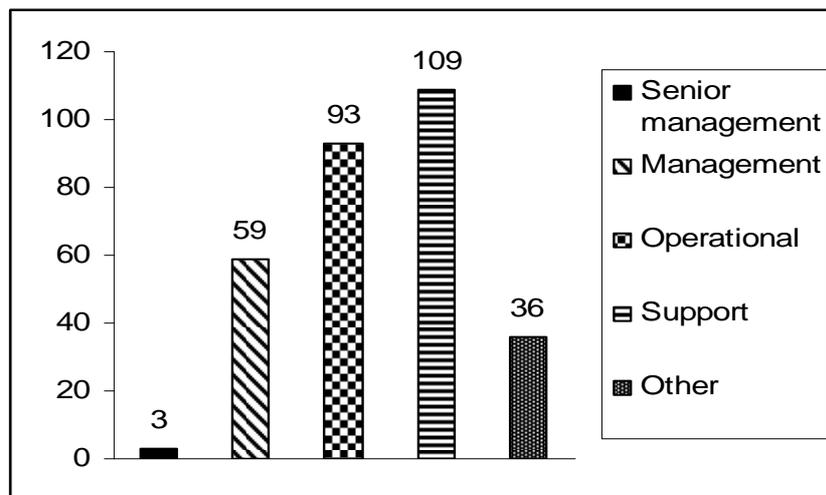
Of the total 389 respondents, 316 reported their employing organisation and 44% of these were NHS employees and 56% were Social Work employees. However, when asked what professional group they belonged to, only 270 people (69%) responded to this question. The results are displayed in table 1.

**Table 1: Professional groups of survey respondents (N=270)**

	n(%)		n(%)
Social Worker	32(11.9)	Psychologist	5(1.9)
Social Care Worker	36(13.3)	Allied Health Professional	26(9.6)
Practice Team Leader - Social Work Services	23(8.5)	Admin & Clerical	61(22.6)
Nurse	53(19.6)	Maintenance/Technical	0
GP/Clinician	2(0.7)	Other	32(11.9)

Due to ethical constraints we were unable to ask about more specific job titles and could not ask further defining questions relating to qualifications or staff grade, in order to protect anonymity. Some respondents might have elected not to answer the job category / profession question above, as they believed this would render their response attributable to them as an individual thereby compromising their anonymity. Information relating to the level at which individuals were employed within the organisation was collected by asking them to describe their daily role as, for instance, operational or managerial. The results are displayed in Figure 4.

**Figure 4: Roles described by survey respondents**



As figure 4 illustrates there was representation from across a range of levels within the CHCP. This further complements the range of participants from the qualitative work and provides the research with a good balance of perspectives from staff across all levels of seniority within the CHCP.

### **Limitations of the Survey**

There were a number of additional limitations of the survey that must be acknowledged when considering the results. Firstly, as the survey was being sent to staff in a newly formed organisation and staff lists and contacts were still being fully established, it is possible that a small number of staff received neither the electronic nor the paper copy of the email. Secondly, the survey instrument is limited in its sensitivity to complex concepts of trust and identity and so whilst providing an overview, lacks the ability to discriminate between certain types of response. For example, some questions refer to the level of trust in senior management. The survey instrument, however, does not provide detail on who the respondent has in mind when thinking of this group (e.g. senior CHCP managers, senior managers from the parent organisations, or perhaps line managers). Finally, but significantly, it is also difficult when interpreting survey data to know whether some of the negative perceptions are related to the CHCP or to other concomitant developments that might be affecting staff (e.g. Pay and Benefits Review, Agenda for Change, service inspections, or changes to professional roles).

### **Analysis of Survey Data**

Survey data was imported to the statistical package SPSS for analysis. Survey data collected by Mori before CHP policy was established will be utilised as a pre-CHCP comparator as similar issues were explored in their survey Glasgow City Council Social Work Services staff (citywide). However, insights from this are partial at this stage as we do not yet have the full picture from our own survey and further analysis across the three time points will be completed after distribution of the follow-up survey in Phase II. This will provide two time periods of analysis for our own survey - one at the start of the CHCP and partnership development and one 2 years on when change initiatives have had some opportunity to take effect.

## **Part B: Qualitative methodology**

The majority of the fieldwork during Phase I has drawn on qualitative research methods, specifically in-depth interviews and observations, with four case studies in different service areas. Together they provided a more detailed examination of underlying perceptions,

behaviours and responses to change initiatives that are fundamental to understanding partnership processes and development, trust and staff responses to the CHCP as an organisation. The observation of senior and operational management meetings and in-depth interviews with CHCP staff at all organisational levels provide insights into the processes of change in relation to partnership development and the integration of health and social care.

### **Observational Research**

The researcher attended the CHCP's weekly East Management Team (EMT) meetings, monthly (now bi-monthly) Professional Executive Group (PEG) meetings, and operational management team meetings in Children's Services and Mental Health. The purpose of these observations was to explore the process of CHCP development, the integration of health and social care teams, and the evolution of trust and identity within the groups, in accordance with the research objectives. Observations were recorded in note form and transferred to a data grid containing categories adapted from Saunders et al (2002). Categories include taking group roles (leading, taking notes), taking the initiative, offering suggestions, being obstructive, challenging group members, and information exchange. The data was recorded systematically in order to reduce observer bias. Additional notes were taken about the specific context of discussions and important points made by individual group members.

### **In-Depth Interviews**

Interviews (of around 1 hour each) were conducted in two stages. The first stage involved a series of 36 interviews with members of the CHCP senior and operational management teams and with members of the Professional Executive Group (PEG). The second stage of interviews (n=73) were conducted with front line service staff in four case study service areas. These were the Child and Adolescent Mental Health Service (CAMHs), Learning Disabilities, Specialist Children's Services for children with disabilities, and the Community Mental Health Teams (CMHTs). These service areas were selected as they represent a variety of stages in the integration and partnership agenda, for instance, Learning Disabilities services have been integrated for around seven years and could provide an interesting perspective and important learning for less integrated services such as areas within Children's Services.

In total, 109 staff members were interviewed on the issues relating to the core project themes. The interviews were semi-structured in nature and incorporated experiences of partnerships and integration, experiences of CHCP development, trust, professional identity and measures of CHCP success. The interviews were conducted in the participants' workplace in a private setting so that participants could speak openly and in confidence. However, this was not

possible in a small number of cases due to lack of space and interviews were, by necessity, conducted in an open-plan setting. This might have hindered responses to some questions.

All interviewees were assured of the confidentiality of their responses and every effort has since been made to ensure anonymity of participants.

### **Qualitative Analysis**

Interviews were recorded and independently transcribed in full in preparation for analysis. Transcripts were quality checked by the interviewee to ensure participants had not been misinterpreted. To ensure that the analysis was robust and to reduce researcher bias, three members of the research team each analysed a sample of the interviews and results were compared before continuing with the remainder of the analysis. Transcripts were coded in line with the interview themes and research objectives.

The coded transcripts were translated into visual maps (mindmaps) so that overall responses for each theme could be seen. These maps were used to inform the write-up within each case study service as well as across services as over-arching themes. Our early and ongoing impressions of the CHCP partnership process were verified through discussions with interviewees (after interviews had taken place) and through presenting early findings to staff and to GCPH members.

The observational data was also collated and analysed thematically in line with the main project themes of CHCP development, trust, identity and performance. Observations were systematically reviewed and added to a timeline of CHCP development which also included other key events that impacted on the CHCP such as new local and national policy, election outcomes, the Social Work Inspection Agency (SWIA) visit, reviews of pay and benefits, and key stages in CHCP development. This timeline will be maintained throughout Phase II for further analysis at a later stage of CHCP development.

### **Research Outputs**

Given the purpose of the GCPH and the openness that the East CHCP has offered the research team, every effort has been made to ensure that output in some form has been provided at the earliest opportunity as a way of giving feedback to the funders and participants. The desire to provide timely feedback has had to be balanced with the need to allow time for a full data set to be obtained. As such, we have so far produced feedback at service meetings, a briefing note

and interim report, and a conference paper and draft of a journal article (the latter has recently been accepted for publication in *Clinician in Management*). A full list of current and planned research outputs is presented in the final section of the report. Following discussion of the research findings and conclusions reported here, a dissemination strategy has been agreed with the East CHCP that includes a series of formats for reporting the work. In addition to this report, a summary will be provided to the EMT and will form part of the basis of a half day CHCP workshop for managers and team leaders on responding to the findings. In addition, there will be tailored feedback to each service area again as a basis for service development discussion. It has also been agreed that the research team will work with the East's Organisational Development team to build workshops around the themes of the report so that the findings are disseminated and discussed as part of a change implementation programme. Finally, we have agreed to work with the East's communications officer to write a short summary of the whole report to go on their intranet.

## Limitations of the Research

Many of the issues relating to partnership working need to be examined longitudinally given that realistically, changes in organisations take a considerable time to permeate and become part of the normal day to day working environment. Indeed, management research suggests that the first effects of change are often not realised until several years after they were instigated. The degree to which aims and visions are shared, for example, would be expected to evolve over time as the new structures are implemented and change processes take effect. Similarly, trust (at various levels) may grow or diminish over time. We have attempted to address this by taking baseline data at the start of the change process (primarily via questionnaire), conducting interviews to explore the questionnaire results in more detail and to understand the issues associated with implementing partnership working. We have also conducted case studies in service areas where health and social care have a history of partnership working and in service areas where there is no such history. However, the 18 months' fieldwork conducted here, can offer only a partial view of change and this has been a significant factor in the award of further funding and allows us to re-issue the questionnaire and conduct further interviews during Phase II of the project. It is important to add, however, that the work here is affected by, and affects, other processes of change and review within health and social care. It is well recognised that in management research, there are problems attributing success or failure to any one intervention because of the vast number of simultaneous changes that take place at any one point in time. In this research, for example, the Pay and Benefits review, undertaken independently of the CHCP developments and this particular research project, had an immediate and direct affect on individuals' views of CHCPs and their willingness to engage with

management and so in any work of this nature, it must be recognised that there are a number of complicating factors that affect the organisational landscape.

## **4 Findings I: Partnership Principles and the CHCP**

East CHCP was established with the intention of a year of relative stability at the outset to enable structures, processes and relationships to form and build before entering any implementation phase for service change. The findings presented in the following sections should therefore be read with this in mind, as they reflect the progress that the East CHCP has made within this context of early development.

The purpose of the research was to identify measures of effective partnership management, to examine the connection between various levels of partnership working, and to explore the nature and development of trust amongst partnership players and the extent to which there was a trade-off between partnership processes (the development of partnership working) and a focus on successful delivery of health outcomes. As noted earlier, there are no established measures of partnership working so for the purposes of this research the frameworks provided by Hudson et al (2000) and by Dowling (2004) have been utilised although our discussion in relation to these frameworks is informed by other published work on partnerships. The first section of findings is presented according to the Hudson et al's six principles, within which are embedded a number of Dowling's process measures (for instance engagement with the partnership, agreement of purpose, trust, accountability arrangements and leadership and management). In the conclusions section, we relate these findings specifically to the original research objectives.

In the second section of our findings an overview of the case studies is presented in relation to interview themes and the research objectives. This enables a more detailed look at the level of the individual service area and a comparative perspective is developed. The final section of the report then draws together these findings and considers the implications for the future development of CHCP and other partnerships across Scotland.

### **Part I: Considering the framework for a 'successful' partnership**

Hudson et al (2000) suggest that successful partnerships are characterised by acknowledgement of the need for partnership, a clarity and realism for the purpose of the partnership along with commitment to, and ownership of the partnership. Other features are trust between partners, with clear arrangements for partnership working and a process to review and learn from experience. These correspond with Dowling et al's (2004) criteria although greater emphasis is placed in the latter framework on leadership and on community

engagement as a measure of success (see figure 5). We should stress here that these emphasise *process* success. *Outcome* success can be understood in terms of improved access to services, equity of distribution, improved efficiency and effectiveness (denoted by service standards, costs and a reduction in the duplication of services), improved experiences for staff, users and carers as well, of course, as improved health and well being. At this stage of the research the findings presented relate primarily to the process measures and the progress the CHCP has made during its first year.

**Figure 5: Principles and Measures of Successful Partnerships**

<b>Hudson et al (2000) Principles of Partnership Success</b>	<b>Dowling et al (2004) Measures of Process Success</b>
1. Acknowledging the need for partnership	1. Community engagement – measured by enthusiasm of partners towards the partnership
2. Clarity and realism of the purpose of partnership	2. Agreement of partnership purpose and rationale – measured by degree to which aims and vision are shared and evidence of interdependency
3. Commitment and ownership of the partnership	
4. The development and maintenance of trust	3. Trust, reciprocity and respect between partners – measured by the confidence partners have in each other
	4. Success in terms of financial climate, institutional and legal structures – measured in terms of whether the political / social environment is conducive to partnership working.
5. The establishment of clear and robust partnership arrangements	5. Satisfactory accountability arrangements – measures include lines of responsibility and appraisal arrangements
6. Monitoring, review and organisational learning	6. Leadership and management – measured in terms of the quality of executive authority over strategic direction, and management towards the objectives.

### **1. Acknowledging the need for Partnership Working**

The first of the principles to explore is *acknowledgement of the need for partnership*. This principle takes account of extent of history, and recognition of need to work in partnership. It also states that a prerequisite of partnership working is that the potential partners have an

appreciation of their interdependencies; without this appreciation, collaborative problem-solving makes no sense (Hudson and Hardy, 2002).

Given the nature and scale of social and health inequalities within East Glasgow, a culture of joint working and partnership has developed within the area. Survey respondents clearly recognised this fact with over 70% acknowledging a history of multi-agency partnerships both within the East and also within their own service area. Further survey responses indicating views of partnership working are displayed in table 2.

**Table 2: Partnership Working**

<b>Statement (number of responses)</b>	<b>SD</b> n(%)	<b>D</b> n(%)	<b>N</b> n(%)	<b>A</b> n(%)	<b>SA</b> n(%)
I think that agencies working in partnership achieve more than those working separately (348)	4(1)	13(4)	67(19)	174(50)	90(26)
I think partnerships achieve more than what just providing extra money would achieve. (347)	4(1)	25(7)	99(29)	155(45)	64(18)
People at my level in my organisation have a good understanding of what's needed for partnerships to work. (346)	4(1)	53(15)	76(22)	161(47)	52(15)
People at my level in my organisation have a good understanding of what causes partnerships to fail. (348)	2(0.5)	46(13)	90(26)	163(47)	47(14)

\*SD-Strongly disagree; D-disagree; N-Neither agree nor disagree; A-Agree; SA-Strongly agree

It was clear from these survey results that staff were positively pre-disposed towards partnership as a concept. This was reinforced during interviews with CHCP staff at all levels of the organisation. In addition, the results in table 3 indicate that the majority of respondents felt they understood the broad purpose of the CHCP.

**Table 3: Views of the CHCP**

Statement (number of responses)	SD n(%)	D n(%)	N n(%)	A n(%)	SA n(%)
I understand what a CHCP is. (344)	13(3.8)	26(7.6)	33(9.6)	216(62.8)	56(16.3)
The CHCP is an important means of working in partnership to improve health. (336)	8(2.4)	13(3.9)	94(28.1)	175(52.4)	44(13.2)
I believe that genuine partnership is achievable between Social Work and NHS. (342)	19(5.6)	47(13.5)	86(25.0)	163(47.9)	27(7.9)
All CHCP members are aware of what is to be achieved through partnership. (342)	41(12.1)	117(34.4)	104(30.3)	73(21.2)	7(2.1)

\*SD-Strongly disagree; D-disagree; N-Neither agree nor disagree; A-Agree; SA-Strongly agree

Some survey respondents did, however, dispute this fact in the earliest stages of CHCP development, as one wrote:

*Speaking to many fieldworkers and managers they are unaware of what exactly the CHCPs are and what they do. Unfortunately they pretend they do so as not to look silly in front of colleagues! True! Ask for detail and they can't give it.*

What was notable from the interviews was that whilst on the whole those with management responsibilities (from senior management to operational management) were familiar with the CHCP objectives and the potential impact upon staff and services, many front line staff were either confused or unaware of what the CHCP was in any detail, i.e. beyond an overall commitment to closer inter-agency working. In terms of enthusiasm for the partnership (Dowling's first process success criterion), it can be seen that staff employed by both partner organisations are enthusiastic about the concept, and the potential of partnership working, but as the next section goes on to show, are sceptical about the extent to which this might be achieved between health and social care. Thus, a crucial issue here relates to managing expectations and leads us to Hudson et al's second principle.

## 2. Clarity and realism of purpose

The second principle is *clarity and realism of purpose*, as most approaches to partnership working take it for granted that an explicit statement of shared vision, based on jointly held

values, is a prerequisite for success (see similar expression in Dowling's 2<sup>nd</sup> criterion of process success). Within this principle it is key that where there are clear differences of values, principles or perspectives, these will need to be addressed prior to partnership development. Hudson et al (2000) also highlight that in developing a vision, partnerships and their members need to be sure it is realistic and attainable for the individuals and organisations participating.

Inspection of the views of the CHCP (see table 3) reveals that whilst staff are positive about the role of the CHCP in potentially improving health, 44% are either unconvinced or disagree that health and social care can work together in partnership. Thus staff believe partnerships to be beneficial overall, but problematic in the CHCP context. Realism about partnership purpose is important (Hudson et al 2000) and it could be that given the history of partnership working, staff are simply being 'realistic' about what successful partnerships entail. The other perspective is that not only are they being realistic, but that there is a considerable proportion of staff who do not believe partnership is possible at all, and that for them to be persuaded otherwise, the CHCP and its parent organisations have a sizeable challenge on their hands.

Given partnership working has been perpetuated through various successive UK and Scottish policy initiatives in recent years, staff in health and social care are not embarking upon partnership working afresh, rather they come with existing inter-agency relationships (formal and informal) and a history of 'transactions' between the two organisations. Against this background, therefore, it is important to note from the results in table 4 that only 39.7% of staff believe there to be already well-established good working relationships between the two despite 60.2% of respondents reporting that they work closely with staff from other agencies. This difference is further evidenced by the fact that 50.5% of respondents are acutely aware of the organisational boundaries that exist between health and social care providers. This also emerged as a key theme within interviews conducted across the CHCP with most participants raising the issue of organisational boundaries unprompted, for instance differences in levels of pay, holidays, dress code and access to equipment.

**Table 4: Partnerships in Practice**

<b>Statement (number of responses)</b>	<b>SD</b> n(%)	<b>D</b> n(%)	<b>N</b> n(%)	<b>A</b> n(%)	<b>SA</b> n(%)
There are well established good working relationships between Social Work and the NHS. (345)	9(2.6)	68(19.7)	131(38)	128(37.1)	9(2.6)
It is realistic to think Social Work and the NHS can work towards the same goal. (346)	9(2.6)	47(13.6)	81(23.4)	193(55.8)	16(4.6)
I already work closely with staff from other agencies. (345)	6(1.7)	30(8.7)	53(15.4)	206(59.7)	50(14.5)
I already work closely with staff from the NHS (if Social Work employee) / Social Work (if NHS employee). (343)	6(1.7)	48(14)	63(18.4)	182(53.1)	44(12.8)
I regard people from other agencies as part of my immediate team/ workgroup. (345)	9(2.6)	90(26.1)	79(22.9)	134(38.8)	33(9.6)
I am not conscious of organisational boundaries when working with staff in other agencies. (345)	23(6.7)	151(43.8)	85(24.6)	73(21.2)	13(3.8)
The time and effort needed to build good partnerships is worthwhile. (346)	4(1.2)	8(2.3)	57(16.5)	218(63)	59(17.1)
I am confident that partnership working will help me deliver a better service to patients / service users. (341)	6(1.8)	28(8.2)	101(29.6)	169(49.6)	37(10.9)

\*SD-Strongly disagree; D-disagree; N-Neither agree nor disagree; A-Agree; SA-Strongly agree

What we cannot tell from the survey results is whether respondents are reflecting on recent inter-agency working or inter-agency working over many years. So, whilst as noted above, there *is* a potentially worrying interpretation, if it is the case that only recent partnership working (or CHCP related partnership working) was in the respondents' mind, then one can place a positive interpretation on the results. It could be argued that whilst there is uncertainty about how health and social care can actually work in practice, there's a good degree of realism, and resilience that despite the awareness of organisational boundaries (which are generally presumed to be obstacles – or at least bureaucratic hurdles), there is scope for health and

social care to work towards a common goal. Moreover, although this may mean staff working harder, it is believed to have the potential to yield benefits to service users and to be worthwhile, albeit time consuming.

In terms of Hudson's characteristics, therefore, it would seem that there is a high level of acknowledgement of the need for partnership working (*principle 1*), but at the early stage of CHCP development there was a variable degree of clarity about the CHCP purpose (*principle 2*) with many staff thinking others don't really understand what the CHCP is. What there does seem to be, however, is a realism about partnership working (*principle 2*) that we would regard as important. We did not come across partnership evangelists who were characterised by enthusiasm but with no sense of reality. Rather, those who had a sense of the potential and value of partnership working tended to be realistic about the effort, time and challenges it would bring.

Interviews with management and PEG members reflected these views gathered in the survey. For instance, amongst CHCP management there was a broadly similar view of the direction of travel although the "specifics" had not yet been clearly defined. There was also an acknowledgement at a senior level that where their own vision was developing this was not translated into a great level of knowledge or understanding of the CHCP at that stage. As one respondent highlighted:

*I think this is a vision that we have to share, shape, create and be interested, if you like but if you asked people in the frontline, what is it they want for the service users...the patients they work with...people will tell you it's about better joined up services and quicker access and, you know. So, in fact, they're communicating it at a micro level, if you like, but if you asked them what a CHCP, the aims and objectives should be, I don't know that they would be able to articulate them.*

However, as CHCPs were set up not to make any major changes within their first year some of the initial perceived 'lack' of clarity might not be interpreted entirely negatively. Added to this were the "unrealistic expectations" placed on the CHCP by their parent organisations, requiring the production of their first annual development plan by only a few weeks after the CHCP was officially launched and before all key staff were in post. This did not provide CHCP managers with any time to consult with staff in the development of early aims and objectives for the partnership. However, managers were clear during interviews and during meetings of the need to consult widely with staff around clarifying direction and developing services. As one respondent highlighted when asked about a clear vision for the CHCP:

*There is with certain people, at certain levels...I used that word 'vision' [but]...vision sometimes...people think it's all kind of cloudy and airy fairy and it's not quite clear. And whereas I think we're very clear where we want to get to which is improving the health of [service population] in the East. So we need to start, I think, being a bit more stated. And within that there are certain things which are givens that we need to achieve. What's not a given is how we do it and that's where all the consultation and getting people onboard come to. But I think we're getting there.*

Another respondent reflected on the initial stability and need for consultation with staff:

*I think nothing has changed really for the teams at the moment. And I think in the lead up to the CHCP we were very much giving out a message, look, on the first of April nothing will be different, nothing will really change, because people were quite anxious about would they be asked to go and work somewhere else, what did it mean...So I think now we're trying to give out a message that there will be changes but they are still on the drawing board, and if people have views about what might be beneficial now's the time to share them.*

As the CHCP moved forward a number of staff events were held to discuss plans with various staff groups across the CHCP. Within individual service areas more focussed days have also been held to engage staff in discussions. Interviewees at the management level did clearly recognise the need for consultation and were engaging in a range of processes to engage with staff. However, within some service areas there were views that consultation had not been sufficient. There were also some issues relating to the process of feedback to staff on the outcomes of seminars and consultations, in particular where this feedback loop had not been followed through. This is discussed in relation to the case study work in the second part of the research findings.

Some of the confusion amongst the wider CHCP staff group was discussed by a number of respondents and suggestions made as to how this could be improved. For instance:

*I think there could be a lot more done in terms of selling the whole concept of the CHCP to the staff that are involved in it. You know what is it all about? What does it mean to us? How are things going to improve? How are decisions made etc. etc. What's the actual managerial process that allow those things to happen? It's about making that all clear to people and where they fit into it and what the priorities are you know.*

Helping staff to see how they fitted into the “*bigger picture*” could also help to improve understanding and clarity around the role of the new partnership, as one respondent discussed:

*...we're probably okay and probably reasonably confident about what we're doing...but, you know there are still question marks about what we do because we don't know sometimes if [what] we're doing...if it actually meets the aims of the CHCP...so it's about how we have a clear purpose, we know what the CHCP aims and objectives and priorities are and the people know what contribution they've got to make to that I think you know I think, I think I'd put more clarity around that.*

This could also be used as some measure of progress in communicating the vision of the CHCP “*if you then go to ask individuals how they see themselves fitting into that if you get a clear answer then that would be, that would be an achievement I think*”. Clearly at that stage there was still a level of uncertainty around the direction the CHCP was moving. However, as noted these interviews took place in the early months of CHCPs life. Since this time the East Development Plan for 2007-10 has been published (East CHCP, 2007). The CHCP still faced some challenges in writing the plan due to the different approaches taken to producing guidance for the development plan by Glasgow City Council (GCC) and Greater Glasgow and Clyde NHS (GGCNHS), and the difference in timing of providing CHCPs with this guidance.

The process of writing the second development plan involved an extensive consultation with staff across the CHCP via forums and meetings, the CHCP website and through professional representatives such as the PEG group working with their own professional groups to gather views on a draft plan. Consultation was also carried out with a wide range of service users and patient's groups across different service areas. The resulting plan contains a clear set of local priorities and the vision for East CHCP:

***To work with our partners and build the capacity of local communities to improve the health, well being and quality of life of the people who live within the area.***

(Source: East CHCP Development Plan 2007-10)

This process has increased awareness among staff and has enabled a greater clarity of the CHCPs role to emerge. Some of these awareness issues will be explored within the follow-up staff survey during Phase II.

What is also of significance here, however, is Dowling et al's point about evidence of *interdependence* between partners. The survey did not include questions about interdependence specifically, whereas interviews (particularly in Learning Disabilities) explored what had been achieved through partnership (within the CHCP or in the past) that could not have been achieved so successfully by either of the partners acting alone. As we discuss further in relation to CHCP performance, it is significant that very few examples were provided in as evidence of improvements/achievements that were derived through working together and that could not have been achieved independently. Thus, one particular issue in relation to both the partnership principle and process success is that there seems to be little sense of interdependence. Given both health and social care have cooperated in the past (where necessary) and have delivered services sufficiently (each would argue) in the past, there is no compelling sense amongst staff that they are dependent on their partners for the delivery of services or for the achievement of overall CHCP objectives.

### **3. Commitment to, and Ownership of, the Partnership**

In their third principle, *commitment and ownership*, Hudson et al (2000) find that research evidence suggests that an organisational commitment to partnership working is more likely to be sustained where there is individual commitment to the venture from the most senior levels of the respective organisations, and that without this it is possible that the efforts of enthusiasts in middle and lower-level positions will become marginalised and perceived to be unrelated to core-business.

Commitment at a senior level is essential to the success of a partnership and can drive partnership working within an organisation. However, the results in table 6 indicate that staff feel this might not have been the case in the early days. It must be stressed that this was in the very early days of the CHCP. It is also not possible to tell from survey results who staff are thinking about when referring to 'senior management', although interviews that followed gave some indication that many staff might have been thinking about senior managers within the parent organisations as opposed to the newly formed east CHCP senior management team.

In considering commitment to, and ownership of the CHCP, we took account of individuals' skills, capacity for partnership working and their own and others' commitment to partnership working. This allows us to see their level of commitment in relation to their preparedness and sense to which they have been prepared for and will be rewarded for contributing to partnership objectives. Taking first the individual perspective, it can be seen from table 5 that there was some mismatch between individuals' perception of their own skills levels in relation to

partnership with 75.8% considering themselves to have a good understanding of the requirements, and their perception of the organisation's understanding of what is required: 51.6% thought the organisation did understand the requirements but a large proportion (58.3%) were undecided or did not think the organisation had a good understanding. Similarly, 45.9% thought the organisation had an intention to support and develop partnership working skills but 54.1% was uncertain or disagreed.

**Table 5: Capacity and Skills for Partnership**

<b>Statement (number of responses)</b>	<b>SD n(%)</b>	<b>D n(%)</b>	<b>N n(%)</b>	<b>A n(%)</b>	<b>SA n(%)</b>
I understand the skills and capabilities needed to work in partnership. (330)	2(0.6)	22(6.7)	56(17)	219(66.4)	31(9.4)
My organisation understands the skills and capabilities needed to work in partnership. (329)	6(1.8)	42(12.8)	111(33.7)	159(48.3)	11(3.3)
My organisation is committed to developing the skills and capabilities needed to work in partnership at my level in the organisation. (327)	8(2.4)	47(14.4)	122(37.3)	136(41.6)	14(4.3)
My organisation rewards those who demonstrate working in partnership with others (eg, through career enhancement, new opportunities, increased salary). (328)	47(14.3)	131(39.9)	125(38.1)	24(7.3)	1(0.3)
My career / salary will benefit if I demonstrate successful partnership working. (328)	55(16.8)	127(38.7)	115(35.1)	29(8.8)	2(0.6)

\*SD-Strongly disagree; D-disagree; N-Neither agree nor disagree; A-Agree; SA-Strongly agree

It is notable that very few respondents thought that they would be rewarded in any way for working in partnership. This is particularly significant for two reasons. Firstly, if it is not seen as being recognised, their effort may be curtailed as they will continually need to balance the interests of inter-agency partnership with other task demands. Secondly, where employees face decisions about career enhancement, they will prioritise those activities that are visible and thought to be valued by the organisation / profession. Whilst there remains a strong element of goodwill and sense of vocation within health and social care, and whilst employees will often still

'go the extra mile', this has been recognised as a diminishing feature of public sector life (Guest and Conway, 2001). Thus, in the face of competing demands and institutional or personal priorities, tasks associated with partnership working may readily become a low priority.

**Table 6: Capacity and Skills for Partnership II**

Statement (number of responses)	SD n(%)	D n(%)	N n(%)	A n(%)	SA n(%)
My commitment to partnership working in my organisation is sufficient to overcome any barriers. (329)	11(3.3)	66(20.1)	134(40.7)	110(33.4)	8(2.4)
There is clear commitment to partnership working from the most senior levels of both NHS and Social Work organisations. (323)	12(3.7)	49(15.2)	145(44.9)	108(33.4)	9(2.8)
There is clear commitment to partnership working at my level in both NHS and Social Work organisations. (327)	10(3.1)	66(20.2)	136(41.6)	150(32.1)	10(3.1)
I think more can be achieved for patients/service users by improving relationships between Social Work and NHS. (321)	2(0.6)	3(0.9)	48(15.0)	195(60.7)	73(22.7)
At my level in the organisation, relationships between Social Work and NHS already work well. (327)	9(2.8)	53(16.2)	141(43.1)	113(34.6)	11(3.4)
Organisational change is needed to improve relationships between Social Work and NHS at my level in the organisation. (326)	9(2.8)	28(8.6)	109(33.4)	131(40.2)	49(15.0)
Organisational change is needed to improve relationships between Social Work and NHS elsewhere in the organisation. (322)	6(1.9)	15(4.7)	104(32.3)	148(46)	49(15.2)

\*SD-Strongly disagree; D-disagree; N-Neither agree nor disagree; A-Agree; SA-Strongly agree

The staff survey also demonstrated that many staff already feel they are working at capacity. For instance, 207 respondents (61%) state that they '*feel rushed doing my job*' and 178 (53%) feel that they '*don't have time to finish their jobs*'. These responses were similar for both social work and NHS staff. In addition a total of 204 respondents (53.4%) felt they are '*working very*

*hard* and 116 (30.4%) felt they are *'working as hard as I can and could not imagine being able to work any harder'*.

In addition to the capacity of the wider staff group for partnership working it is also important to consider the capacity of CHCP management, in particular in the very early days of partnership development. As the new management teams came into post and took on new roles there was a continuous pressure to *"hit the ground running"*. However, managers were also learning new systems, new organisational language and culture. Senior managers all spoke during interviews and meetings of the sheer volume of work that existed daily, added to the by all the additional work created by the formation of the new partnership. One respondent highlighted some of the issues encountered at this time:

*I would say the main challenge is the fact that you've got people from both sides of the health and social care spectrum who are in the process of trying to learn about one another's world, so there's all that going on just now as well as still having to cope with the day-to-day business. And the day-to-day business is tricky because there's issues that obviously as a partnership you don't have a common set of HR policies and procedures that fit for everyone. So you need to have an awareness of each of the organisations' policies and procedures, and you also need to have an availability of someone on occasion from the parent organisation to deal with certain issues.*

Some individuals were moving from lead roles into operational management roles, and others were moving from operational management into more senior strategic management, and hence were adapting to new styles of working and taking on many additional responsibilities, as well as learning to delegate existing roles to new managers and staff within their teams. All interviewees at management level referred to the steep and fast learning curve that was faced at the outset. Support amongst managers was crucial at this time and interviews and observations at meetings all highlighted the way in which the new management team bonded as a group, in part through the arena of mutual support that was created. Some members of the central East team based at the Templeton building felt this supportive atmosphere was aided by the open-plan office facilities which enabled the team to bond and work openly at a very early stage. Inevitably this arrangement also created some difficulties at times where staff required privacy and a quiet environment to complete work. A move to new accommodation has since been completed in September 2007.

The results in table 7 highlight staff's views that organisational change is needed to improve relationships between health and social care throughout the organisation. The barriers noted

earlier in table 4 in the context of a history of initiatives to encourage inter-agency working are likely to have heightened awareness of the degree of organisation-wide effort and change that is required. This is particularly clear when we discuss later in the report issues of inter-professional working and professional identity. Where we do have a word of caution is in relation to the perceived effectiveness of change in the past. The results in the table below show that there is only a minority of staff who would agree that their organisation has been associated with successful organisational change in the past, and a high level of staff who are unconvinced that problem solving initiatives achieve their intended purpose. Given staff are of the view that organisational change limits their ability to do their job well (although they are willing to accept that change is a necessary part of organisational life), one can interpret these findings as indicative of a degree of apathy or passivity to change. In other words, there's an inevitability that change is a constant feature of organisational life, that it creates an ongoing level of interference with performance, and that given there is limited evidence (in the minds of the respondents) of previous success, only a moderate effort will be made towards effecting change.

**Table 7: Organisational Change**

<b>Statement (number of responses)</b>	<b>SD</b> n(%)	<b>D</b> n(%)	<b>N</b> n(%)	<b>A</b> n(%)	<b>SA</b> n(%)
My organisation has been associated with successful organisational change in the past. (316)	18(5.7)	56(17.7)	105(33.2)	120(38)	17(5.4)
Most of the initiatives that are supposed to solve problems around here don't do much good. (315)	7(2.2)	61(19.4)	121(38.4)	95(30.2)	31(9.8)

This perspective whilst somewhat disappointing to those seeking to bring about change, is not uncommon, and it should be considered in light of the fact that the survey and interviews nonetheless demonstrate a willingness in principle to work in partnership.

In light of these findings, a further essential ingredient for creating commitment and ownership is leadership of the partnership. This not only relates to the most senior level but at all levels throughout the partnership. The appointment of a CHCP Director and formation of a senior management team brought together a team who had to adjust to their own new roles and also adjust to each other's different styles of leadership. Differing styles did at times cause some frustration despite a broad level of support across the team. A series of organisational development schemes and staff development days also assisted in the development of a strong team. However, in the early stages there was some tension between central versus local control

as managers were being asked to respond to centre-driven demands (from the parent organisations), which then impacted on their time for staff development.

A range of different leadership skills may be useful at different stages of partnerships development and hence the variety of skills within the management team would be beneficial to the CHCP. For instance, earlier in the development of a partnership facilitation and listening skills will be required to engage diverse and representative membership; later, when a partnership has developed a strong identity, negotiation and advocacy skills may help bring about changes that are less feasible politically but important to a partnership's mission (Sullivan and Skelcher, 2002). Leadership across the CHCP could also be diversified by identifying 'CHCP champions', a concept that has been successful in promoting previous partnership ventures and engaging with the wider staff group (Mackenzie et al, 2003). Consequently these individuals were essential to the collaborative process and success of some partnerships (ibid).

CHCP managers acknowledged the potential for such 'champions' at an early stage and recognised that 'middle-managers' and team leaders played an essential 'buffering' role between senior managers and frontline staff, enabling communication and increasing understanding between them. Team leaders across the CHCP were seen as essential in helping to get staff on board. These individuals will need to be skilled at networking and developing relationships not only within teams but also across organisational boundaries (Sullivan and Skelcher, 2002). Their success in the role will depend on them being perceived as unbiased and able to manage multiple points of view; being perceived as having sufficient legitimacy to assume the role; having a sense of the critical issues and first steps that need to be taken; and having political skills that can encourage others to take risks (Mackenzie et al, 2003). If the CHCP can utilise team leads and individuals across the CHCP with these skills they will be able to play a key role in the continued development of the partnership.

These leaders across the CHCP will clearly have a key role to play in managing the change at an organisational level and in bringing their staff on board and guiding them through periods of change. This will be crucial within the context of CHCPs as demonstrated by the results in table 8.

**Table 8: Managing Change**

	<b>SD</b> n(%)	<b>D</b> n(%)	<b>N</b> n(%)	<b>A</b> n(%)	<b>SA</b> n(%)
Constant change within my organisation prevents me from doing my job as effectively as I would like. (315)	4(1)	45(14)	74(23)	124(39)	22(68)
There is a willingness amongst my colleagues to accept ongoing changes to how we work. (314)	21(7)	74(24)	82(26)	130(41)	7(2)
I will be able to adjust to changes as they take place. (315)	4(1)	8(3)	58(18)	208(66)	37(12)
It is clear to me what changes my organisation wants over the coming year. (310)	34(11)	99(32)	101(33)	72(23)	4(1)
It is clear to me how my role will change over the coming year. (312)	62(20)	126(40)	77(25)	45(14)	2(0.5)

\*SD-Strongly disagree; D-disagree; N-Neither agree nor disagree; A-Agree; SA-Strongly agree

It is clear from these results that staff feel that organisational change interferes with their ability to deliver their work. There is also a lack of clarity and degree of uncertainty relating to what changes might be happening to staff. This is an important area for managers to communicate with staff in order to keep anxiety associated with change under control. What is also important to note, however, is the resilience of staff to change with 78% of respondents stating they will adjust to changes as it happens and 43% feeling there is still a willingness among colleagues to accept changes. This final point also highlights a further 26% of respondents who are undecided but an important 31% of respondents who do not feel there is a willingness to accept this change. This will clearly have implications for the CHCP as it moves forward to implementing change within services areas that are being developed and it is also the case that commitment will vary as other internal and external events take effect. These issues are also discussed later in relation to professional identity and the case study work.

#### **4. Development and Maintenance of Trust**

*Developing and maintaining trust* is the fourth of Hudson et al's partnership principles and the 3<sup>rd</sup> of Dowling's measures of process success. This is because although joint working is possible with little trust between those involved, the development and maintenance of trust is generally regarded as the basis for the closest, most enduring and most successful partnerships (Hudson and Hardy, 2002; Alvarez et al, 2003; Neilsen 2004). The survey found that there was a high level of trust between day to day colleagues. For example, 93% of respondents believed that their day to day colleagues would help them out if they got into difficulties at work, could be

relied upon to do what they said (84%) and would not do anything to make the respondent's work life more difficult through carelessness (67%). Some of these respondents would be responding with peers from the same organisation in mind (e.g. their NHS colleagues), but given some service areas within the CHCP have a history of partnership working and are already integrated, a significant proportion of respondents would be responding with colleagues from the partner organisation in mind.

**Table 9: Trust in your colleagues**

	<b>SD</b> n(%)	<b>D</b> n(%)	<b>N</b> n(%)	<b>A</b> n(%)	<b>SA</b> n(%)
If I got into difficulties at work I know my day-to-day colleagues would help. (383)	6(1.6)	5 (1.3)	17(4.4)	195(50.9)	160(41.8)
I can trust the people I work with to lend me a hand if I need it. (383)	7(1.8)	6(1.6)	26(6.8)	208(54.3)	136(35.5)
Most of my colleagues can be relied upon to do as they say they will do. (381)	4(1.0)	10(2.6)	47(12.3)	231(60.6)	89(23.4)
I have full confidence in the skills of my colleagues. (380)	3(0.8)	13(3.4)	79(20.8)	199(52.4)	86(22.6)
Most of my colleagues would get on with the job even if managers were not around. (380)	5(1.3)	18(4.7)	33(8.7)	200(52.6)	124(32.6)
I can rely on other colleagues not to make my job more difficult by careless work. (379)	9(2.4)	33(8.7)	83(21.9)	189(49.9)	65(17.2)

\*SD-Strongly disagree; D-disagree; N-Neither agree nor disagree; A-Agree; SA-Strongly agree

Trust in line management was also good, although not as strong as amongst peers (table 10). Line managers were thought to be considerate of others' viewpoints (64%), and offered reasonably timely feedback (53%) and truthful feedback (64%). It is notable, however, that there was a higher number of responses in the neither agree nor disagree category throughout these questions in comparison with responses for peers. The most obvious explanation for this is that because of changes in line management structures, particularly where there are new professional leads, line managers are 'untested' and staff have had little opportunity to decide on their line manager's trustworthiness.

**Table 10: Trust in your line manager**

	<b>SD</b> n(%)	<b>D</b> n(%)	<b>N</b> n(%)	<b>A</b> n(%)	<b>SA</b> n(%)
My line manager always considers my viewpoint. (377)	20(5.3)	49(13)	68(18)	187(49.6)	53(14.1)
My line manager is always able to suppress personal biases. (377)	22(5.8)	52(13.8)	113(30)	144(38.2)	46(12.2)
My line manager is always able to give me timely feedback about decisions and their implications. (376)	27(7.2)	70(18.6)	80(21.3)	154(41)	45(12)
My line manager always treats me with kindness and consideration. (376)	14(3.7)	36(9.6)	68(18.1)	178(47.3)	80(21.3)
My line manager always deals with me in a truthful manner. (375)	17(4.5)	41(10.9)	77(20.5)	165(44)	75(20)

\*SD-Strongly disagree; D-disagree; N-Neither agree nor disagree; A-Agree; SA-Strongly agree

A lower level of trust, or a higher level of uncertainty, was found in relation to views of senior management (table 11) where respondents were asked to assess integrity, fairness and competence of senior management. This was the case across all sections with few staff either strongly agreeing or strongly disagreeing with the statements and the majority of staff selecting 'neither agree nor disagree' with the statements.

**Table 11: Trust in your senior management**

	<b>SD</b> n(%)	<b>D</b> n(%)	<b>N</b> n(%)	<b>A</b> n(%)	<b>SA</b> n(%)
Senior management is sincere in its attempt to meet the employee's point of view. (379)	37(9.8)	99(26.1)	172(45.4)	64(16.9)	7(1.8)
I feel confident that my organisation will always try to treat me fairly. (379)	48(12.7)	97(25.6)	130(34.3)	96(25.3)	8(2.1)
Senior Management are well placed to competently lead this organisation. (378)	27(7.1)	77(20.4)	179(47.4)	86(22.8)	9(2.4)
Senior management can be trusted to make sensible decisions for the organisation's future. (377)	40(10.6)	88(23.3)	174(46.2)	67(17.8)	8(2.1)
Senior management at work seems to do an efficient job. (378)	32(8.5)	70(18.5)	180(47.6)	87(23)	9(2.4)

\*SD-Strongly disagree; D-disagree; N-Neither agree nor disagree; A-Agree; SA-Strongly agree

The higher level of trust amongst day-to-day colleagues than in senior management is perhaps to be expected. It is particularly the case here because at the time of the survey the CHCP was still very new. As senior managers had been appointed to their roles only 4 months before the survey was conducted they had had little opportunity to demonstrate their trustworthiness or competence in any sphere other than at a senior level amongst their peers. As the full extent of the integration envisaged by the CHCP continues to take effect, it is at this point that the degree and nature of trust in line and senior management will be more visible:

*I haven't detected any serious tensions about people thinking there's anything to be untrustworthy about. And I think a lot of that is to do with the front-line staff...they're not seeing the immediate changes, maybe it's only when those changes start to take effect... that's when the new challenges have come up for us to sort of reassure people and make sure that there isn't a breakdown of that trust, and people thinking there's things going on behind their back.*

### *Types of Trust*

What is particularly positive is that although trust in senior management here is found to be lower than at other levels, it is in fact higher than has been found to be the case in other public and private sector organisations even where they have a more stable environment (Guest and Conway, 2001). This may be indicative of a high degree of institutional trust with CHCP staff believing their respective employing organisations would make good decisions about CHCP appointments and that safeguards are in place to remedy problems where poor decisions are made. Given many changes are yet to take effect, and there are simultaneous processes that may potentially damage trust (e.g. Pay and Benefits review), we do not yet know whether institutional trust (if that's truly what is being demonstrated) will be sustainable.

*For many a lot of people in the front line they're not seeing the immediate changes, maybe it's only when those changes start to take effect, then might some of that, you know, that's when the new challenges have come up for use to sort of reassure people and make sure that there isn't a breakdown of trust.*

What is more likely to be sustainable is the reported high level of trust in peers that was also reflected in the interviews. This was seen to be largely knowledge based trust (i.e. trust that comes from knowing a particular individual and being confident in their behaviour given past experiences of working with them) or identification based and personal trust, where trust derives

from having a common set of values and reference points (e.g. a history of working in the same service / geographical area or belonging to the same professional group).

Where relationships have formed most closely, i.e. at the senior management level, it seems the case that the high level of trust is largely social in nature, based on group identity, duty and commitment rather than rational (i.e. based on individual gain) as the following quote suggests:

*I've seen people, the barriers are down, people are genuinely talking to each other, they're genuinely listening to each other and, from that, obviously, builds trust... trust doesn't just come with the post...but I think, ... there's a, both a professional trust and a personal trust, to varying degrees with individuals but enough, for me, to feel secure enough that that's the Management Team that I would want to be part of.*

### *Maintaining Trust*

As Hudson and Hardy (2002) highlight, maintaining trust is important for sustaining partnerships over the longer term. The high level of trust between front-line staff, and trust in their line management would seem from the interviews to be largely due to existing social and inter-agency (albeit previously not formalised) relationships. Staff frequently referred to the fact that they had known X or Y for years, and had worked in a joint project in the past. This personal knowledge gave them confidence or trust in one another. This occurred in an environment where inter-agency relationships were by and large idiosyncratic, i.e. down to the individuals themselves rather than based on agreed institutional partnerships. These existing ties mean that the CHCP has a trust-based climate already in which staff involved in delivering services have a level of trust that has developed over time. This has been evident in observations at EMT meetings where historical relationships have been brought to the CHCP table and have contributed to a comfortable and supportive environment for, for instance, more difficult discussions relating to service developments and budgets. That trust is based on knowledge of one another is, however, problematic when people move jobs outwith the area. Institutional links, on the other hand, are more readily preserved if not person-specific.

A shared professional background (e.g. common training) also plays a significant role in creating and sustaining trust, although it cannot be assumed that simply because two people are, for example, nurses that they will automatically trust one another. Thus, we can say that there is a high level of peer-peer social trust at the front-line level, there is a similar level of trust amongst senior management but that trust *between* the levels is not consistently as high and a large proportion of staff remain to be convinced about whether or not they would have trust in

senior management. There is an issue here, therefore of not only maintaining, but gaining trust in the first place.

Given trust is something that develops over time (a factor acknowledged throughout this report and as a basis for the extended funding), there are certain aspects of inter-personal and inter-institutional trust that cannot be fully understood at this time but that will be explored as the study continues. It is the case, for example, that early trust-based relationships where there was no history between individuals, was difficult to create as staff tended to start in their roles at various points in time. However, the intensity of EMT working meant that the early EMT group were able to form close bonds, common vision and a degree of trust in one another based on early evidence that individuals were knowledgeable, experienced, would deliver in terms of their role, and with that came respect and trust. However, it is also the case that to only a limited extent have SMT and operational managers been 'tested' in terms of delivering according to key objectives and agreements. As further decisions are made about resource allocation, priority setting and performance, it is at this point that political dynamics within the CHCP will either cement trust-based relationships or will increase 'calculative trust' (i.e. assessing the extent to which individuals can be trusted to act in their own interest).

Perceptions of takeovers have been evident in the early stages of CHCP development as soon as we move outside of the EMT group. Rummery and Coleman (2003) found that "*if trust and enthusiasm for partnership working is to be maintained, then one side cannot be seen to be completely taking the process over; it has to be a joint activity in which both sides benefit*" (p1781). Some findings revealed that social work staff have felt more threatened by partnership working than health, possibly reflecting a perceived status of the two services. However, similar views have also been expressed by some NHS staff who see CHCP developments as a social work 'takeover', revealing that perceived threats are being experienced across both organisations. These perceived threats have been recognised across the CHCP by managers, as demonstrated by the following two quotes representing both organisations:

*Well, everybody believes that the other dominates...So whatever side of the house you sit in they believe the other side are more dominant. I think that personally the money is always going to be the more dominant and at the moment it seems to be health.*

*It's just strange and there's obviously the worry that East Glasgow is heavily weighted with social workers in the management positions and that was a worry to begin with.*

There was also a recognition that perceptions may very dependent on your position within the CHCP:

*I think to be fair there were probably fears on both sides. There was fear of, I can remember doing a lot of the groundwork...which did help me come to understand it, it wasn't so much about a takeover it was about disentangling an old system and re-emerging as a new entity and if you remember that then, you know the CHCP is a much clearer structure and you can, you can accept the fact that it is a joint structure. Unfortunately maybe depending on where you are in the system and how much information you have you're perception of what's happening is not always like that, it feels very much, and I think from both sides to be fair having spoken to operational managers, of a take over.*

Where there were perceptions of takeovers the profession became an important framework for employees, who will defend it if it is under threat. Moreover, some respondents felt that a line manager should be from the same profession in order to understand the role and values. This system has caused difficulties in the early CHCP days for some staff, while others have felt more supported through the changes (see Case Study findings).

Another respondent highlighted the need for emphasising the positive aspects of integration as a way of beginning to overcome staff fears of a 'takeover':

*I suppose working in a people organisation, the main challenges are around people's concept of their own professional identity is to ensure that, it's not about take-over, or it's not about consuming one part of an organisation within another part of an organisation. I think that the challenges have to be about reassuring people that we're trying to take the best of both organisational values and principles and bringing those together because I think we've got more in common than we do have different as a service provider to bring those values and principles together.*

What has been clear during observations of the EMT is that these factors are fully acknowledged by senior managers. However within the EMT the strong collective identity which developed very quickly has led to behaviour which demonstrates trust among colleagues, such as supporting each other on difficult service development issues and through the steep learning curve presented to service managers as the CHCP was launched. Phase II of the research will enable further exploration around maintenance of trust at this level as the CHCP moves forward

to more focussed implementation of service changes, and further analysis of how trust develops throughout the CHCP as any changes begin to impact on the daily roles of staff.

## **5. Establishing Clear and Robust Partnership Arrangements**

The establishment of *clear and robust partnership arrangements* forms the fifth of Hudson et al's principles (2000), and should be as unambiguous and straightforward as possible in order to avoid excessive bureaucracy. Within this principle it is essential to be clear about finances and other non-financial resources, such as experience and knowledge that can be provided by partners and their constituents. Successful arrangements also require partners to be clear about and accept divisions of responsibility when have joint plans.

The CHCP has had only 18 months in which to establish partnership arrangements. It is not surprising, particularly given Glasgow has opted for a more fully-integrated CHCP model than other CHPs, that partnership arrangements are taking time to establish. It is evident from the discussions that have taken place in EMT meetings that there is a high level of understanding amongst senior management about the nature of the engagement between health and social care services within the CHCP, and much effort has been directed towards setting timescales for delivering against partnership and service objectives. Where partnership arrangements have been more problematic during the development stage are with respect to the following areas:

- the 'fit' between health and social care in terms of organisational culture, including disparities between pay and conditions, at the management and frontline level, between health and social care staff;
- understanding the CHCP structure and developing the roles of constituent groups and committees;
- the development of a clear CHCP identity across all staff groups; and
- the impact of integration on professional identity.

### *Cultural Fit*

There is a consistent view across the CHCP that Social Work Services and the NHS are very different organisations. Thus, whilst at one level they share common goals, their means of travel towards those goals differs considerably. There is little opposition to the view that a medical and a social model are still in operation within parts of the system, although there are

areas where this is perceived to have become far more blurred due to the nature of services and the care that they deliver. Although notions of a 'medical' and 'social' model of care are no longer espoused in research and educational terms but have been replaced by the population and individual perspective on health improvement, there would appear to be a dislocation between theory and practice in the context of the CHCP. We do not know why this is the case. One strong possibility is that as staff have sought to maintain their professional identity (by restating occupational boundaries), this in turn may have caused them to reinforce differences by reference to yet further significant boundaries between a 'health' and a 'social' perspective. This is something we will explore in Phase II of the work. What we can note here, however, is the potential problem for CHCPs, that in many respects it would seem as though partnership working has served to heighten awareness of differences in cultures, whilst not always being able to overcome them due to constraints within the systems of the parent organisations.

Co-location of health and social care staff, where it exists, has many advantages. This view was shared by CHCP management and staff alike during interviews, including breaking down some of the existing 'barriers' between professionals and enabling a better understanding of each others roles to develop. However, it has also served to further highlight differences between health and social work at the operational level. These differences could be particularly difficult to overcome for two reasons. Firstly, much of the difficulty arises from the sense that individuals are seeking to retain their sense of professional identity and many see the integrated model of CHCPs as potentially diluting that. This issue is discussed in more detail in relation to the case studies in section 5, and has been written about by the research team in some detail elsewhere from a more academic perspective (Pate et al, forthcoming). The second reason is that significant differences in the culture (by which we mean aspects such as practices, norms and symbols), of the NHS and Social Work are notable. In addition to pay differentials, there are considerable variations in terms of working hours, public holidays, entitlement to equipment such as lease cars and mobile phones, and then different IT systems, incompatible confidentiality rules around patient/client information, and, in the views of some, a corporate culture within social work versus a more professionalised and hierarchical culture in the NHS. It is particularly significant that within Learning Disabilities services, arguably the most developed service area in terms of partnership working and integration of health and social work staff, there was perhaps less expectation of integration in terms of overcoming these arrangements (given partnership working pre-dated the CHCP), as these problems prevailed during their own integration process and still do (see section 5).

During interviews participants frequently raised the issue of pay differences between health and social work. Throughout the CHCP there are disparities in pay that have been highlighted

where teams have been integrated. For instance, a qualified nurse might be paid the same or less than an unqualified social care worker, despite having additional professional or line management responsibilities attached to their role. Although not all of these issues relate specifically to partnership arrangements, they are seen in the eyes of staff as issues relating to CHCP structure and the development of the integrated model so must be considered accordingly. As integration across a new range of service areas continues this is also likely to become an issue for more staff and the CHCP will need to develop robust responses to this. Within Learning Disabilities and Addictions services where integration is already further developed similar issues were encountered, and in some cases still exist. It will be important for the CHCP to draw on learning from these service areas and evidence of success relating to the integration process.

Since CHCPs began both the NHS (Agenda for Change) and Local Government (Pay and Benefits Review) have been through significant reviews of their pay and benefits structure and this has had an impact on staff within integrated services:

*I'll be quite positive about people co-locating and working together but I think there are huge differences in the cultures and their ways of working and the ways of even thinking about individuals. I think that always causes a friction... Well, the pay and benefits review is causing a lot of issues in social work at the moment, but it's once people are co-located they start getting issues about hours of work and holidays and differences like that, and you know, these kind of grate on people, I think, when they're trying to work together.*

These reviews of pay and benefits also have important implications for managers considering service developments:

*...both organisations have been going through a massive pay and conditions review as well. And, you know, that becomes in some ways a major focus for staff, and you could try and get them coming up with new ideas about how you might restructure and reshape the service, but if that's right in the middle of a terms and conditions and pay review, and people think that by being creative and changing a job they might actually be in a position of detriment you're hardly going to get them on board. So we've got a dilemma there about people's personal aspirations in wanting to feel they've got the kind of guarantee of that's what I'm earning after this review, now I can move on with what we do about rejigging the structure because I know I'll be protected at that. So there's a wee bit of reluctance, I think, for people to get fully bought in to some of the big changes until they're*

*reassured, I think, by the outcomes of agenda for change and the pay review for social work.*

### *Groups and Committees*

The second aspect of developing clear and robust partnership arrangements relates to understanding the CHCP structure and developing the roles of constituent groups and committees. As the CHCP has developed it has become clear from interviews that there remains some uncertainties around the roles that different groups play within the CHCP structures (see figure 1, p5), and how they relate to each other in terms of flow of information and decision making processes. Interviews at an early stage of CHCP development particularly reflected these views. For instance, the following quote illustrates confusion around the role of the CHCP Committee:

*I don't really know how they work to be honest. I don't even know how often the [Committee] meets or anything like that you know, what sort of things they discuss how it operates, I don't, I think their agendas and all that are probably published in the websites and things like that but I don't have a clue how that whole process works...and then how the senior management operates below the [Committee] meetings and that kind of thing...but I really, really don't know how things are prioritised either and, as obviously there will be a tension between some of the social work things and NHS.*

Clarifying these issues among staff groups will be important in developing a greater understanding of the CHCP and how and why service development progresses. Clear lines of communication between the Committee and other groups will be vital, as will a clear flow of information from management and Professional Executive Groups (PEG) to the wider staff group that they represent. Without this information and understanding it will become more difficult to keep staff engaged with the CHCP development and direction of travel.

At the time of the interviews taking place with management and PEG members there were still a number of issues relating to the role of the group and structure of meetings that were still being discussed and developed. The PEG was described by senior management as an “*important group to have on board*” as they recognised the role they could play in making decisions about service development, although the extent to which that had happened at that stage (winter 2006-07) was questioned. This was, however, at a very early stage of CHCP development where a decision making role might not have been required at that time. The PEG also suffered initially as people's roles changed and some individuals left the group or joined at a later date.

The group therefore went through a slightly extended period of 'bedding in' and developing their role and professional relationships across the group. As one respondent highlighted:

*It's whether people are going to stick around long enough and make that commitment, that's the thing, isn't it? You can't really join a PEG for a year and walk away. Well, if you walk away I think that affects the stability of it because of anybody new coming in as an outsider, because we're going to form a clique in the end.*

Early perspectives of the PEG group varied between some members, as one respondent expressed a positive view of opportunities:

*...on the PEG it's been good. You work in [service] and that's your world. Here in the PEG [service] is a small part in the...CHCP you know. It fits in with a lot of things but you can see where the priorities are. It opens your eyes to what else is going on and how you can link in and how you could maybe joint work...and I think that's quite good that you know, that the PEG offers you that opportunity to take in a network.*

Others discussed the membership of the group with some members feeling that there was a good balance of representatives on the group:

*I think it's very early days yet, I think the PEG is still going through a big norming and forming stage. It's clear that the PEG has a role as Professional Executive Group, it is made up with the right, it's populated with the right percentage of people, so many from each profession. It still has to be clear what is going to go to the PEG but more importantly how does that information come out of the PEG.*

However, some questioned the membership:

*I think the potential is there without a doubt...From my perspective I think there's far too many people on the PEG group it's not all... it's called the Professional Executive Group but there are people who are not what I would class as professionals on it, so I have to ask the question [why] are they there. And therefore, if I'm asking that, I'm wondering if I've got a grasp of what the PEG should be about.*

There were also some views expressed about the organisational balance of the PEG group with some feeling that the group was very clinically driven. However, there were also a number of others who felt that the group was very social work driven. The content of meetings is likely to

vary at times and views of members along with that. In the early stages the PEG was criticised by some members who felt little commitment to the group and “*didn't find it a valuable use of time*”. However, PEG members have acknowledged these difficulties and have responded by re-developing meeting arrangements. The structure of the meetings has since changed to a bi-monthly arrangement and a series of themed working groups for more in depth discussion around specific issues have also been established. These smaller groups will subsequently feed into the larger PEG group for a wider discussion around service development issues and for any necessary decision making.

Some members also questioned the ability of such a diverse range of professionals to find a common view during consultation on specific issues, despite having a role to play in information sharing:

*There's all sorts of provisions there, so a very, very heterogeneous group of people. It could be, probably will be, rather useful in the sense of an exchange of information or an opportunity to express views, but I could hardly imagine the PEG group like speaking with one voice on just about anything.*

A further view expressed the challenge facing the PEG group:

*The PEG hasn't made any decisions that I'm aware of, which is not meant to be unkind, but it's ... that's going to struggle I think. It's such a big group. It's potentially a huge agenda. And it's all independent contractors and all the rest of it. It's been really interesting I think because I've learnt a lot of what other people do and you learn a lot about people's priorities. But I think the PEG is a really challenging group.*

However, as these views were expressed at a relatively early stage of development, it is likely that the new structure of the PEG system will resolve this issue at least to some extent. This illustrates the difficulties faced by a partnership such as the CHCP in finding the balance between representation of professional groups while maintaining meaning and commitment across such a large and diverse organisation. The EMT and CHCP Committee could play a role here in helping to set out and clarify the precise role of the PEG group. While the PEG is perceived to be a potentially valuable group the extent of their power within the CHCP to influence decisions and service developments has been unclear at an early stage. Setting out these aspects more clearly would provide a clear remit for PEG members.

There were also a number of concerns raised during interviews across the CHCP relating to how the CHCP can engage meaningfully with the independent contractors, including GP, Dentist, Community Pharmacy and Optometry colleagues. Currently the PEG is the main forum for this. This issue is not explored further within this report due to the more limited nature of data collected in this area. This will form a central component of Phase II of the research.

A further set of relationships to be considered within the context of the CHCP partnership arrangements are those between local structures and the central structures and systems of the parent organisations. Members of the EMT did not appear to feel more dominated by either the NHS or Social Work Services. However, there is a view that while systems and control has been devolved more to the CHCP from the 'centre' in the NHS, there "*remains a whole industry at the centre of social work*". This created frustrations from an early stage where managers were running 'integrated' service areas but remain accountable to two different parent organisations, with their own systems for budgets and performance management. As the CHCP has developed more control has been devolved to the local level from both centres within specific areas. At some level this devolved control has brought with it some of its own challenges that staff have had to adjust to, as one respondent highlighted:

*I think there's definitely tensions, simply because custom in practice has been that a lot of decisions would be referred over to centre, and maybe that was easy for people not to take the sort of management responsibility and deal with it. I think the difficulty we have now is that people are being told, yeah, you do have to take the responsibility, but they're not being fully empowered to do so, there are still individuals in the sort of central part of the organisation that are retaining some responsibilities, and I don't think it's been made absolutely clear where does that end, and where does your part begin. And if you're going to assume responsibility for certain areas of the service, where is the budget and the backup resources that are going with that? And I think that's a difficulty people are having.*

In addition to these relationships between 'centre', the CHCP has had to develop systems to work with a range of citywide partnerships, the Mental Health Partnership, the Glasgow Learning Disabilities Partnership and the Glasgow Addictions Partnership. Here exists a further layer of administration and accountability that link directly with the CHCP who are responsible for the delivery of these service areas at the local level. Local services now potentially had a two-pronged management system which caused some early challenges. This was particularly the case within Learning Disabilities and Addictions services as there was initially no 'Head of Service' for these areas at CHCP level. Instead interim arrangements meant that Operations Managers from within these areas acted as 'Interim Heads of Service' within the CHCP senior

management team. However, their contribution was restricted as decision making powers had not been handed to them; this was still retained by the city-wide partnership. This inhibited the capacity of these individuals to play an active role in the EMT when they could contribute to discussion but decisions had to be taken back to the partnerships to which they were accountable. This created a sense of lack of clarity and some sense of confusion among staff within these services around the lines of accountability. The interim arrangements for these two service areas were consequently reviewed and Heads of Service appointed. This did not take place until around ten months after the CHCP was launched.

However, these early arrangements also added a layer of complexity in relation to who staff within the services identified themselves with – was it the service, the city-wide partnership, or the new CHCP partnership? And to whom were they ultimately accountable? These issues are explored further in the presentation of case study findings.

### ***Professional and Organisational Identity***

Issues of organisational and professional identity have emerged as key themes within the research. The survey gave some early indication of staff views of organisational identity. Table 12 highlights that although staff (66%) did have some interest in others' views of their organisation, that overall organisational identity was not particularly strong.

**Table 12: Organisational Identity**

	<b>SD</b> n(%)	<b>D</b> n(%)	<b>N</b> n(%)	<b>A</b> n(%)	<b>SA</b> n(%)
When someone criticizes my organisation it feels like a personal insult. (368)	21(6)	99(27)	100(27)	132(36)	16(4)
I am very interested in what others think about my organisation. (367)	7(2)	26(7)	91(25)	209(57)	34(9)
When I talk about my employer I usually say 'we' rather than 'they'. (366)	23(6)	90(25)	90(25)	144(39)	19(5)
My organisation's successes are my successes. (363)	13(4)	54(15)	156(43)	122(34)	18(5)
When someone praises my organisation, it feels like a personal compliment. (364)	16(4)	71(20)	140(38)	120(33)	17(5)

SD-Strongly disagree; D-disagree; N-Neither agree nor disagree; A-Agree; SA-Strongly agree

A collective identity has developed at EMT level and this has been evident from an early stage of partnership development. This became clear during interviews with EMT members and during observations of EMT meetings. For instance, at a very early stage of CHCP development EMT members referred frequently to ‘us’ and ‘we’ when speaking within meetings about the CHCP, rather than referring to their individual service areas. However, the interim Head of Service arrangements did not help this process as within both Addictions and Learning Disabilities services a three-monthly rotation system was in place for the two Operations Managers within each service area. This meant that as one individual was becoming known and ‘accepted’ as part of the group, and was familiar with discussions and service development issues, then the rotation would occur and a ‘new face’ would attend meetings for the next three months.

The CHCP structure brings together a range of professionals within new frameworks of accountability and service delivery involving team-based services, integrated measures of quality and outcomes, shared knowledge and models of care, language, practices, standards, measures, and feedback. In effect, this brings a core dimension of what it means to be a professional worker into focus and leads to the question of whether working in partnership affects individuals’ sense of their own professional identity. During interviews at all levels across the CHCP the issue of professional identity has also emerged as a key issue within the CHCP partnership arrangements. These high levels of professional identity were first identified by the survey. The results presented Table 13 clearly indicate high levels of professional identity amongst respondents.

**Table 13: Professional Identity**

	<b>SD</b>	<b>D</b>	<b>N</b>	<b>A</b>	<b>SA</b>
When someone criticizes my profession, it feels like a personal insult. (364)	10(3)	50(14)	64(18)	184(51)	56(15)
I am very interested in what others think about my profession. (363)	6(2)	13(4)	70(19)	206(57)	68(19)
When I talk about my profession, I usually say ‘we’ rather than ‘they’. (361)	5(1)	28(8)	79(22)	189(52)	60(17)
My profession’s successes are my successes. (362)	6(2)	29(8)	133(37)	150(41)	44(12)
When someone praises my profession, it feels like a personal compliment. (361)	8(3)	33(9)	115(32)	167(46)	38(11)

SD-Strongly disagree; D-disagree; N-Neither agree nor disagree; A-Agree; SA-Strongly agree

There is a clear awareness and acknowledgement of professional issues at the management level within the CHCP, and these issues have been discussed regularly at CHCP meetings. CHCP management demonstrated awareness of a range of issues later raised by staff within the case studies such as suitable accommodation for integration, the need for some “*blurring of professional boundaries*” and the need to maintain specific professional skills within a team while utilising generic skills to best meet the needs of the service users. However, where there is a clear awareness of these issues at management level, there still exists a high level of anxiety at the level of frontline staff. A number of staff have felt threatened in terms of their identity and role as services move towards a more integrated structure. A range of interesting issues around professional identity emerged and are discussed further in relation to the case studies.

Some managers were acutely aware that some staff groups had faced a number of difficult challenges in addition to the emergence of the CHCP structures:

*The [profession], at the moment I think there's a lot of challenges for them. They've undergone a lot of changes in relation to their pay and conditions, a new record keeping system, so there's been a lot of challenges for [them] at the moment and quite clearly its about defining the role of [profession] within the wider integrated working team, whether you are integrated together as people the care delivery to a [care group] and the level of integration within it and who's directing it, who's leading it, where do you begin, where does it end.*

Many interviewees did acknowledge the need to develop professional roles within an integrated context, as illustrated by the following quote from one respondent:

*So but increasingly we can see...there's a blurring of roles and you need to be able to fudge the roles a wee bit. And it's not clear cut. And increasingly, we just need nurses that are flexible and we need social workers that are flexible, and can bob and weave a wee bit, and adjust to what's required. Because if folk are going to stick to rigid nursing tasks, to rigid social work tasks, it doesn't work. It doesn't work like that.*

However, the way in which staff are educated and how their training and professional experience impacts on the professional mindset about their role and delivery of care will be a key issues here. If the CHCP does want staff to develop their professional roles there is a clear training need for staff, particularly where concerns are raised about competencies required for specific roles. Some professions appear to relate more closely to each other where the type of

training led to a similar ethos for service delivery. Where professions felt they delivered a very different role to colleagues, for instance a nurse and a social worker, concerns were raised around a move towards a more generic role as this might erode professional skills and have an impact on future career development and promotion opportunities. The case study work highlighted some examples of the concerns around the concepts of 'generic workers' (see following section).

The importance of learning from those service areas further down the integration route was also raised by a number of managers, as illustrated by one respondent:

*Well, I think there was professional identities enhanced by that [integration] because they're beginning to respect and understand what other people do, and other people understand what it is they do. And, okay, there'll always be arguments around the margin...But you'll always get that, but then I think people understand that other people bring slightly different things and that you can work together. And when you're in a team of different people you see who's the most appropriate person for each case. I think it will enhance it.*

And similarly:

*If you ask others in the partnerships who work for integrated services, they're an integrated team, they've done it anyway. They've done it and they've come out the other end. And they're actually very positive about it. And we can learn from them, the pain that they went through and try and avoid some things. But they're actually very positive in that being in an integrated team far from weaken the professional role and the professional, the distinct professional element, it's actually to strengthen that. Because more than ever you had to say why is it a nurse that needs to do that and why not a social worker?*

However, staff elsewhere within the CHCP do not all share this view, and these issues are discussed further in relation to the case study findings in section 5.

A further impact of the CHCP at the professional level has been through the disruption of existing professional structures. Early interviews across the mid-management and PEG interviewees revealed that these disruptions had created some uncertainties for management and their staff. For instance one managerial respondent commented:

*...you know from my own point of view there's, there are some rules that, I would like to know where does that person sit in relation to me because as a senior [profession] now I have no [professional] hierarchy above me...*

The impact of these structural changes has already been felt by some respondents:

*I think there has been a change in that professional lead structure, there's no doubt about that, I mean, the job I was in...if a decision was to be made, a sort of policy decision around about how the profession were moving in line with professional standards anybody anywhere in the city could contact one person and they could get a collective view and that could be taken back and then it would be implemented and one person would lead on that implementation. So there's a bit of fragmentation there.*

It is clear that the impact of changes in professional structures has been felt across the CHCP at all levels. At a managerial level this has led to uncertainties in lines of communication relating to decision making. At a frontline level concerns have been raised around professional support and the impact on continuing professional development. This has been evidenced within the case study work later in the report.

## **6. Monitoring, review and organisational learning**

The sixth and final partnership principle outlined by Hudson and Hardy (2002), is *monitoring, review and organisational learning*. It is key for partnerships to monitor the extent to which collectively agreed aims and objectives are met and to review how well the partnership is working. Where necessary, reconsideration and revision of partnership aims, objectives and arrangements can act as a refining process towards a more efficient and effective partnership.

In relation to this final principle there are a number of factors involved. Ultimately 'success' of the partnership will be measured in terms of improved health and well-being of its service users and constituent population. However, this is inherently difficult to measure due to difficulties with the length of time required to detect changes in population health and difficulties with attributing any progress to a particular policy or initiative (Mitchell and Shortell, 2000). The CHCP is required to respond to its parent organisations and the Scottish Government with a full series of performance management data as part of its continual monitoring and review process. However, this process of completing the Joint Performance Management Framework is not

perceived to be a helpful process and discussions within the EMT have highlighted a number of difficulties around the statistics that are produced at a central level, upon which CHCPs will be judged. Observations have highlighted frustrations that some statistics are misleading and do not accurately reflect the progress made within particular service areas or with a specific initiative. Although the CHCP will continue to respond to the required performance frameworks, every effort is being made to expand methods of performance management. This will include the measurement of 'soft' targets such as the experiences of staff and service users.

In addition to this the CHCP has now developed a clear set of service objectives and key performance indicators around which its continued development will be closely monitored. It is widely accepted that the first year of new partnership development is required in order for structures and systems to be set up and refined, and the development of detailed objectives will then follow. At this stage of the research it would not have been realistic, or indeed fair, to begin to explore the progress the CHCP has made against some of these indicators. This will form a key component of Phase II as the research team begin to combine this progress with the CHCP timeline of events that has been recorded. As the CHCP moves forward this will enable an exploration of what progress has been made, alongside any factors that might have influenced the CHCP strategy, and will begin to build a rich picture of the CHCP story.

The EMT have taken a number of steps to enable review and learning in the early days. There is a detailed programme of Organisational Development work, as required of all CHCPs, for the development of staff across the CHCP. In addition to this the EMT have had a number of development days to work on the relationships within the team, but also to begin to develop a clear strategy for the CHCP across each service area and collectively as a partnership.

Some of the processes of team development have not always been perceived as successful, and some EMT members have been sceptical about the use of certain work. Some have also questioned whether they have led to any real change within the EMT and, for instance, the structure and function of meetings. There has, however, been recognition of difficulties and gaps and attempts have been made to redress these.

The EMT have also been very open to this research, allowing observation of many CHCP meetings and enabling the continued participation of staff. This again demonstrates a willingness to reflect on current practice across the partnership.

### *Measuring success*

Interview participants were asked to reflect on how they might begin to measure the early success and progress of the CHCP during its first two years, in terms of the organisation. Many participants found this quite difficult to articulate, particularly given the size of the agenda facing the CHCP, and responses were varied although most related to improvements to services and a high quality of care for service users.

Many of the responses also reflect an awareness of challenges raised by the wider staff group, as shown in the earlier findings presented here. For instance, in relation to partnership arrangements measures of success included the development of robust structures, clarity of lines of management and accountability and also clarity around the roles and functions of groups and committee's within the CHCP. A key part of this will be to ensure a clarity of structure in terms of how each part of the CHCP relates to each other and how individual roles of staff contribute to the overall aims of the CHCP. Some of these issues will be explored in the follow-up survey during Phase II. Similarly the research can explore stated measures of success such as awareness of the CHCP and recognition as its own entity, and any evidence of a developing CHCP identity.

Interviewees felt that protected time for organisational development would be an indicator of success. Related to this willingness to learn, a number of participants raised the importance of learning from those services that were already integrated, particularly Learning Disabilities and Addictions services.

A further set of success measures centred on improvements in communication and understanding between organisations, service areas, and professional groups. Clearly some of this could also be enhanced by improved IT systems, a fact raised by the majority of interviewees. Participants also expressed a wish to see CHCP staff becoming more empowered to take part in decision making and service developments, and some felt that an annual feedback from staff about how they feel and any problems they had experienced would be a positive step.

This research set out to explore the development of objective measures of partnership. This has been very difficult to do at this stage and many of the measures emerging from interviews are largely subjective measures. However, during Phase II the team will work closely with the CHCP to explore how they might begin to measure progress and successes against those more objective measures proposed by Dowling (2004), as well as some of the more measurable factors set out above.

## 5 Findings II: CHCP Case Studies

The following section presents an overview of the key findings from the four case studies within East CHCP. The four areas were highlighted for the research due to the varying stages of integration they have reached, and all included both health and social work colleagues. The cases were:

1. Learning Disabilities (LD) services which have been more integrated than other service areas for around eight years due to a move from the old institutional-style of care to a community-based model for adults with learning disabilities. The service provides a range of health and social care needs to individuals and their families and carers;
2. Community Mental Health Teams (CMHTs) are multi-disciplinary teams based in resource centres in three locations in the East CHCP. They provide a service for adults aged between 16 and 65 with severe mental health problems and form part of a broader mental health network across the area;
3. Children and Adolescent Mental Health Teams (CAMHs) provide specialist, multi-disciplinary interventions for children and young people with moderate to severe mental health problems. The children's and adolescent teams have recently joined to form a single team; and
4. Specialist services for children with disabilities (SSCD) currently provided as individual services, with joint working across the different groups. East CHCP is the host for citywide Specialist Children's Services and is currently working with these services to develop a more integrated, community-based approach to the delivery of services for these children, their families and carers.

The aim here is to provide analysis of the key issues which impact on all of these service areas, and to highlight some of the differences relating to the stage of integration or joint working that each service has reached. As highlighted in the methods section, the interviews with case study participants covered four broad areas of discussion which aimed to capture data responding to the research objectives. In order to provide some comparison across the service areas the findings from the case studies are presented according to these themes:

- Partnerships and the CHCP
- Trust

- Identity
- Measuring CHCP Performance

As noted earlier in the report, East CHCP was established with the intention of a year of relative stability at the outset to enable structures, processes and relationships to form and build before entering any implementation phase for service change. The findings from the case studies reflect this early stage of CHCP development.

## Partnerships and the CHCP

Case study participants were asked to give an account of their own perceptions of the CHCP to date, and their experiences of partnership working. Most participants agreed that it was still very early days in relation to the CHCP and at this stage the majority of participants have seen little or no change to their daily activities. Changes that had occurred were at the level of systems such as Human Resources and Finance, for instance:

*No changes have affected the work with families. Changes so far have been above that, for example where we go to for budgets.*

As this quote illustrates, many participants felt that changes were happening at a 'higher level' than frontline services, and decisions at a senior level had not yet been translated into frontline service changes. This varied to some extent across the case studies, for instance Learning Disabilities services are already working within an integrated model and further changes were not planned at the time of interview. However, within Specialist Services for children with disabilities (SSCD) it was clear that participants were aware of forthcoming changes to services and re-location of staff which, although it had not yet happened, was the focus of the discussion during interviews. For instance, among staff working within individual SSCD services that are currently city-wide there was a degree of confusion over how services might change with new CHCP boundaries. Although the SSCD services are now hosted by East CHCP they are still providing a city wide role. Concerns included the impact on some services, e.g. withdrawing services from families in North Lanarkshire where an equivalent service does not exist. Some staff also expressed concern that services might be split up into smaller teams across different areas of the city, having a negative impact on the service provided.

Although there were a range of issues and anxieties relating to the development of the CHCP and integrated service models, at the broadest level the majority of participants appear to agree

with the idea of closer working relationships between the NHS and Social Work Services and greater integration of services. However, it is the level and type of integration that is of concern to some staff, particularly in relation to the service provided and a range of professional issues. Participants also discussed the scale of the agenda the CHCP faces. Although the new structures have raised awareness among some staff of the need to work with other agencies, a minority of interviewees indicated that the goal of the CHCP was admirable but not realistic:

*The CHCP needs to become much more humble in their beliefs in what is needed to get change and need to be more realistic about it.*

The definition of partnership and what it might mean within the context of the CHCP was discussed with participants and for many it equates to joint working between services:

*Sharing the information about what you found and about what you're doing with a particular [service user] but also maybe to get together and have joint plans, joint aims and things like that and thinking about how all the different agencies interlink as well with a [service user] instead of just saying 'well, you know, this is what I found, this is my aim and this is what I think is my aim' actually thinking about how that all works together, yeah, so that's the way I kind of see it happening.*

However, where there is a widespread acceptance of the need for joint working, and indeed a strong history of joint working within each of the case study areas, there are a range of issues that need further attention if partnership working and integrated practice is to come to fruition. As discussed earlier, the NHS and Social Work services are viewed across the CHCP as very different organisations, with clear working cultures and practices. However, participants across the case studies also discussed the fact that there is a common set of values that exist across the two organisations; it is the approach that differs.

For instance, within SSCD it was felt that different interests groups held varying agendas, which could be a barrier to joint working:

*It's all very different, I mean everybody is kind of so different, you know, when you speak to them and everybody has their own agendas and their own goals and things like that so it tends to be very much... for most of the children it tends to be very much just information sharing.*

It was clear that despite the varying degrees of joint working and integration across the case studies there was a common view of the need for a greater understanding of services, the roles they play and the different thresholds at which they operate. Learning Disabilities services still face challenges of inappropriate referrals into the service and a number of interviewees hoped that the introduction of the CHCP might lead to greater understanding of their service across the area and therefore lead to more appropriate referrals for service users.

Similarly, a number of participants within the CAMHs team raised concerns that there was 'no common understanding' of mental health across health and social work colleagues. They raised the need for some clarity and definition to aid understanding of services and their boundaries and to manage expectations of colleagues. A further issue exists around the different thresholds at which health or social work services will intervene in the life of a family. For instance, where discrepancies have been highlighted in how cases are prioritised, due at least in part to organisational and team capacity to intervene, this has the potential to lead to tensions between partner organisations. There was broad recognition across children's services of the different language and thresholds that currently exist between organisations, such as the range of definitions and interpretations of the term 'vulnerable', and the point at which an organisation can and does intervene. As one respondent highlighted:

*There is a different threshold of access between health and social services, for example cases where health where we would need to intervene...it actually goes to social services and their threshold is higher because they do it day in and day...it is on the radar with them but it doesn't cause a massive intervention which health thinks it should.*

Understanding across a broader set of agencies is also key to successful partnership working, for instance working with education colleagues to provide children's services. Some services find this challenging due to differences in expectations across partner organisations, and indeed within their own organisation, as to how a service operates, their referral procedures and how waiting lists operate:

*I think that sometimes a barrier in that a lot of people are very frustrated by us because we've got such long waiting lists, so people can refer to us and it'll maybe be ten months down the line that the child will get seen and I think education... first of all education find that quite difficult to deal with because maybe we're going into that school to see another child and you think 'well can you not just see him while you're in.*

A further comment highlights difficulties faced around where the boundaries of services meet and how these can be clarified through greater integration to the benefit of the service user to ensure more efficient services are delivered:

*So there's a difference there and the problem with that is that health then have to implement these things on their case load and don't discharge the case because social services won't take over. There's a lot of inappropriate cases being kept on and referrals coming into the system which might not be appropriate...I think one of the things about integrated services when they get together I actually think it can help that because if you've got a joint agreement where health and social work are working in the same team and looking at everything that comes in there's a way that things like that can be filtered, inappropriate things can be filtered out before they reach there because they are then part of a joint assessment as to is it appropriate for the team or not.*

Some of these tensions relate to the capacity of organisations and teams to be able to respond to referrals or carry out greater joint working with partners. Capacity to form relationships and negotiate new ways of working is a necessary requirement for partnership working and any organisational change initiative. However, interviewees indicate that capacity to deliver services does not allow for additional time to be spent developing relationships across organisations. Within Learning Disabilities services and the CMHTs where staff are working with integrated teams or have been co-located for a number of years relationships have developed further and understanding between organisations was not a major issue within interviews. Greater difficulties existed within service areas where health and social work colleagues had more limited direct contact. Within the SSCD case study individual services are still situated in different locations around the city, with a range of discrete health services working jointly with social work on individual cases. Within the CAMHs team social work staff were now co-located with health colleagues and were seen as an important bridge between health and social work colleagues. Their presence within the team was seen to have increased understanding among many health colleagues about how social work operates as an organisation, and increased understanding of systems and decision making processes. However, the capacity of these few individuals is limited and the CAMHs team staff regularly link with the broader social work area teams to discuss cases.

Across these children's services there were clear concerns among health colleagues around the capacity of social work to respond to individual cases. What is vital to stress is that although this concern translated clearly into frustrations among health staff around, for instance, a lack of contact with social work staff or unreturned telephone calls etc, there was also a clear

understanding across all health staff that the difficulties lay with the social work *organisation* and *systems* rather than with individual social work staff. The following comments illustrate the resulting frustrations among health workers:

*I haven't had much contact with social work. I have tried to contact them for advice but had difficulty making contact with them. I can't track people down.*

However, this difficulty was also acknowledged by social work colleagues:

*I know health colleagues can get frustrated sometimes if they make a referral and then they don't get an instant response, you know. A referral comes in and there's concerns but they're not major concerns when, I suppose, they will keep phoning until, you know, they want the i's dotted and the t's crossed straightaway, and sometimes just the pressure on the service, we can't respond immediately.*

This is an area that will need careful management as the CHCP develops, particularly where closer working ties and are required between social work and health colleagues as they become more integrated teams. These concerns that the social work system “*is in a real mess*”, with high sickness absence levels and high numbers of unallocated cases are viewed as a potential barrier to integration:

*Certainly in the East End of Glasgow it's a mess and that is a huge barrier actually, to the work that takes place and for the ability to work jointly and to integrate, because how can you work a case jointly, if two months after you've opened it the social worker goes off sick because they are under so much stress and so much strain.*

As services move towards more integrated working, issues of capacity at different levels within the case study teams have also been highlighted. For instance, the CAMHs team's relatively recent integration of the previously separate Children's and Adolescent teams have further highlighted concerns of under-resourced services within the former children's team and planning for staff shortages. Concerns were also raised about the loss of the team's social worker at the Child Development Centre and the impact this has on joint working across organisations.

What is clear from the case study work is that concerns around capacity and the more anxious perceptions of the social work system arose in services that were integrated to a lesser degree than, for instance, the Learning Disabilities teams and CMHTs. This raises the issue of how the

CHCP manages expectations and concerns around capacity as services move forward over the next twelve months.

In relation to the early development of CHCP structures and systems there were a range of views across the case study areas dependent on the stage of service development and any change they were experiencing. As illustrated in section 4 the vision for the CHCP was still emerging at the frontline level.

Staff within the LD case study were quite clear about the structure of their own services and integration of health and social work staff. This included the 'matrix' structure of the service management whereby health and social work team leaders would have responsibility for staff employed by both organisations. There was some initial uncertainty relating to the management structures above the level of the team as staff within the service still view themselves as part of the pre-existing Learning Disabilities city-wide partnership. As this partnership stands alongside the new CHCP structure some staff were uncertain who they were ultimately accountable to, and how the LD partnership and CHCP related to each other. As one respondent highlighted:

*...it's becoming clear what the vision is ... but [we're] caught between the two [LD and CHCP].*

Within LD services there was a sense among some participants with a line management role that the CHCP vision or 'identity' was becoming clearer at the time of interview, and there was no sense from any interviewees that the two would merge. Some interviewees voiced confusion about the future role of the citywide LD partnership if greater responsibility within this area was to be devolved to the CHCP. However, it was also evident that other health and social work colleagues within LD services did not yet have a clear view of the CHCP vision or direction of travel.

Within the SSCD case study, service redesign was at the stage of development and consultation at the time of interview. For this reason the vision for these services was less clear among participants. For instance, the decision making process surrounding service development was a topic of discussion for many, and many felt that the full plan for the CHCP must be formed in the minds of senior management but that it just had not yet been fully communicated to the wider staff group. Some staff were, however, sceptical about the consultation process:

*They must have a good idea what's going on, but it looks like we're being involved but actually not.*

This in turn has had some impact on the levels of trust in management, a point that will be discussed further in the following section.

Due to the early stage of service redesign within SSCD services there was also a degree of confusion among respondents within some services around who their employer was, lines of management and structures for professional support. This led to comments such as “...it feels like we're in no man's land at the moment”. For instance some staff based within Yorkhill Hospital are now managed by the East CHCP. This resulted in new structures and contacts for these staff and some links within the Yorkhill base had been removed, for instance, human resources, health and safety etc leading to some initial uncertainty around procedures. However, these were largely viewed as “teething problems” associated with large scale change that would be resolved.

One of the main issues associated with the CHCP development relates to the process of integration for the different service areas, and the resulting experiences of staff. While the majority of staff support the idea of closer working between health and social work colleagues, it is the degree of integration which leads to varying degrees of anxiety and raises challenges for the change management process as the CHCP develops. The four case studies are at very different stages of joint working, co-location and integration.

Where services are less integrated, such as with the SSCD case study, some participants were unclear of plans for the relocation of teams within a community setting and co-locating teams that currently occupy hospital or social work bases. A further dimension of these models for service redesign and co-location of SSCD teams relies on the communication by senior management of the rationale for this:

*There needs to be an understanding of each professions philosophies and time to understand a profession and why they are locating certain people together – who impacts the most on who?*

This is particularly the case for individuals who have previous experience of co-location and found it isolating:

*I have experience of collocation and it was very isolating with no contact with other [professional colleagues]*

Within the CHCP context, for instance, there needs to be consideration of how staff are located. Where current city-wide teams are located together there are perceptions and anxieties that they might be separated into smaller teams around the city. While this would have the benefits of co-locating staff within multi-disciplinary teams there could be some detriment where professional contacts are lost or reduced. This was particularly considered to be an issue for newly trained staff:

*I've needed my colleagues round about like if there are situations or if there's, you know, you would bounce stuff off them, I don't think it's healthy just to be on their own.*

A further comment also relates to the potential negative implications of dividing up specialist teams and possibly reducing the 'pool' of skilled workers:

*Now, what's happened with the advent of CHCPs, is these citywide services have been devolved into locality services. But I'm not sure that they will remain as highly skilled and competent, because you could do a big skill mix of professionals when you get a citywide, area-wide specialism, but if you break that specialist workforce up, you actually end up with a very small amount in each of the CHCPs.*

This was a clear concern among participants within SSCD. It has important implications for how the CHCP redesigns services and how, if services are divided, they work to support the continuation of professional networks within the new structures.

### **The process of integration and change**

Any organisational change can be an anxious time for those involved and it is a process which requires careful management at all levels. The CHCP must also be aware of messages that filter out from services where, for instance, an integration process has already occurred and the influence this might have on the views of staff in other services. For instance, some respondents within LD services were extremely negative about the process of change and integration that took place in LD services in recent years. Others echoed less strongly some of these sentiments. There were some perceptions that particular professional groups were "lied to" about new service and staffing models during the change process. The consequence of this process is that some staff still feel disengaged from the service a number of years later. Many of

these anxieties relate to the professional identity of staff. As other service areas move towards more integrated models of service delivery a careful change management programme will be required to respond to any similar issues that arise.

### **Co-location of CHCP staff**

Levels of integration vary across the case study services. Within LD services both health and social work staff are employed as Care Managers within the teams alongside other health and social work colleagues. In other areas such as the CMHTs and CAMHs teams health and social work staff are co-located within the same premises, and in the case of the CMHTS within the same office space.

The majority of case study participants felt that co-location of health and social work staff was beneficial and is seen as having a key role to play in improving communication and breaking down perceived and real inter-professional barriers. Within those case studies where staff are already co-located (LD, CMHTs, and to some extent CAMHs), co-location was perceived to have improved communication and understanding across all professional groups, i.e. not only between health and social work staff. For instance, the co-location of the former child and adolescent teams when they were brought together to form the CAMHs team was viewed as a positive move, particularly where progress is compared to other areas where child and adolescent teams have not been co-located:

*The thing is the coming together of the teams is still at a very early stage. It's more advanced across [the East] team than it is in other teams because they're still at a stage of more joint working. Honestly it's much easier...it's probably more advanced because we're in the same building.*

Co-location is viewed as having increased understanding across professional groups as well as different organisations and their systems. This is now quite well developed for staff within LD services and the CMHTs. Some staff felt that an important outcome of this was an improved service for the individual:

*I think working in the same, you know, all in the one office is much better because you get to know the people better as well. And I just think... I just see there's a vast improvement with it. And I think the service the [service users] are getting is much better, as well, for it, and that's what it should be.*

However, not all respondents were convinced that co-location is beneficial for the service user:

*I'm not entirely convinced that working in a closer proximity if this facilitates [multi-agency working] any better, it makes informal communication a bit easier the more that goes on but I wouldn't have said it facilitates, it's made a great difference to the patient care if you like, because I'm still doing these things anyway.*

In addition to these issues, co-location, where it exists, further emphasises differences between the partner organisations and professions, yet also has the dual effect of placing greater onus on staff to find ways of working together. There is evidence of success within LD services both in terms of finding ways of communicating amongst a range of disciplines and benefiting from exposure to multi-disciplinary perspectives. These were frequently cited by participants in LD although the journey to improved communications was bumpy, with some conflict on the way. What was potentially surprising from the case study work and given that LD services have a longer history of integration is the fact that there are still issues over inter-professional working where *"..lots of discussion [is] needed around skills and values"* until there is a *"shared understanding and acceptance"* of colleagues. However, these issues are not only related to the integration of health and social work staff, but also to integration or closer working between different parts of the LD service. Currently the area services team (Social Workers, Nursing staff, Care Managers etc) are co-located in the same building as Day Services Staff (Social Care Workers, Assistants and Service Managers), a move that occurred around two years ago. Despite this, the two were described by respondents as being quite separate, and in some instances it appears that a 'them and us' scenario has developed. The ongoing nature of this was highlighted by one respondent who said *"people have not bonded ...bridges need to be built"*. A number of the interviews with LD staff who have had several years in which to overcome partnership challenges, yet have continued to find that, despite considerable effort, professional and cultural differences are an ongoing source of tension. Hence, although LD services are further along the road of integration in some respects, there are clearly still issues associated with the process occurring at a number of levels within the service.

A further tension arises where co-location, whilst bringing people together, highlights the institutional differences discussed earlier (see section 4), such as differences in pay and conditions. This was an important issue discussed during case study interviews, particularly within LD services and the CMHTs. The close proximity of staff has highlighted a wide range of differences in pay, conditions and working practices. This has been further enhanced during the past twelve months due to the reviews of pay and benefits that both the NHS and Social Work Services have been through. The outcome of these reviews and ongoing tensions around them

will continue to be a major issue for the CHCP in the coming months until pay disputes are settled and strike action has ended. However, even beyond this it is likely that staff working in integrated teams will continue to be affected by pay differentials. It is a testament to the staff working within services that they have continued to work in relative harmony and develop relationships with colleagues despite some of these difficult issues.

## Developing Trust

Although trust forms one of our research objectives, at this stage of CHCP development it is only possible to make some limited early observations relating to how trust has developed within services and between colleagues and management. Within the case studies there were issues relating to trust at three levels: trust in the colleagues, trust in management, and trust in the organisation(s). Some of the main issues at this early stage of development are considered below.

### Trust In Colleagues

As the survey results presented earlier highlighted (see page 40), there is a high degree of trust between colleagues. However, it emerged during interviews across all case studies that while a degree of 'professional respect' was placed in individuals, trust was not automatic just because of a person's profession, even between staff within the same professional groups. Trust within services was more likely to be based on a personal knowledge of someone's professional practice, and the majority of interviewees indicated that it was important to get to know an individual before trusting them, i.e. developing personal trust, as illustrated by the following quote:

*When working with other staff in services that are strangers, it's not that you don't trust them just that you don't know them. It's about communication, the way you relay information to people and it takes time to trust and it's also about knowing your boundaries.*

This can be a complex process, particularly within multi-disciplinary teams, and there is a steep learning curve for individuals to understand other professions:

*I think a lot of it comes down to understanding what the professionals do and what they see their role as, and maybe you have an equal understanding of their role, and I think*

*equal agreement of what their role is. And I think I do trust people more of professional when I understand what they do and I understand what their job and what their role is, and I know that that's what they'll do.*

As other case study services, for instance the constituent services of the SSCD, move towards service models of co-location and integration this will be a key area for development.

Past experiences of joint working between health and social work as organisations, and between different professional groups has been mixed and this will undoubtedly impinge upon the current context. As one respondent discussed:

*And I suppose because traditionally, past experience it's not always been the best with [profession] because they've got different agendas, so I suppose there is probably going to be a wariness about involvement with them.*

In addition to developing personal trust between colleagues, some case study participants suggested that the profession was a vehicle for trust, as well as the level of an individual's qualification. Perceptions of the abilities of 'qualified' and 'unqualified' workers within organisations, particularly social work did cause some anxieties among health staff.

The majority of participants appeared to feel there were high levels of trust within their teams. In some cases these teams remain uni-professional, for instance the SSCD case study where service redesign has not yet reached the implementation stage. High levels of trust were also evident within multi-disciplinary teams, and more integrated health and social work teams. For instance the CAMHs team was described as "*supportive*" and "*non-hierarchical*" with a good understanding among team members of their different roles and contributions to the team. One respondent highlighted some of the characteristics of the team that led to trust developing:

*...in a multi disciplinary CAMHs team it's much more of a, this is a team and we'll work together. There are some certain recognised people who might be leaders not necessarily by position it can be by their nature or by position but it's much more democratic...you feel as if you have much more to say and your views are much more considered when decisions are made.*

However, it was also recognised by CAMHs team members that trust and relationships could be placed under more pressure during periods of stretched capacity and anxieties relating to service developments. At this stage the relationships appear to be strong and supportive.

Similarly within the CMHTs participants described a “*feeling of mutual trust and respect among colleagues*”. However, once again there have been some issues as service developments occur that have the potential to impact on teams:

*And the thing that, particularly with the changes to the Mental Health Act, some of the Social Work team are, I mean, the bulk of their time is taken up with the Mental Health Officer role you know... So I encourage people here not to see it as an individual thing ... It's an organisational thing, you know, and we have to work with each other and ensure that people have a good working relationship, and it's not personal.*

It is clear that the CHCP will need to ensure understanding of these individual roles and statutory duties within teams in order to enable the development of stronger relationships. Despite some of these issues having the potential to interfere with team development, some of these have been successfully managed within teams:

*And I would say that all the kind of rapport between the staff is generally quite good. They may well have differences of opinion, but there's forums here where you can express those opinions without it kind of affecting anybody.*

These high levels of reported trust among colleagues will undoubtedly provide a source of support during service redesign and implementation. Phase II of the research will enable further exploration of the role of trust as teams move through different developmental stages across the CHCP.

### **Trust In Management**

According to the survey results presented earlier (see page 41) trust in line management was reasonably high, although not as high as in colleagues, and trust in senior management was lower, yet appeared as yet to be undecided by many staff.

There were a number of factors across the four case studies that contributed to views of management within the CHCP. Within LD services trust in service leads (Operational Management level) was quite high and staff were comfortable with the open style of management. Some concerns were raised about senior management as previous negative experiences during the integration of LD services were now, to some extent, being reflected upon the current developments and key members of the CHCP and parent organisation management teams. This particularly related to staff who felt their professional identity was

threatened by the integration process (see following section). However, as these earlier experiences remain associated with partners that are now part of the core CHCP structures, some staff might find it more difficult to develop a higher level of trust in the partnership and members of management at this level. The key factor in this instance will be how the teams are developed and led in the future. In this instance the role of Team Leads within LD services will be crucial to bringing staff on board and developing relationships within the team, and in forming a 'bridge' between frontline staff and higher levels of CHCP management. Participants in LD services appear to have quite a good level of trust in team leaders and their "open-door" approach. The matrix structure of management of staff from both health and social work had also increased understanding of roles of the different professionals within teams.

Within LD services, the most challenging area relating to trust, or mistrust, between colleagues, was the perceived barriers that lie between the Area Team and Day Services Staff. Although this view was not universal there are clear issues for staff and team development in how these parts of the service work in a more joined up way.

The role of 'middle' managers and team leaders will also be key to the development within other areas of the CHCP. Within the CMHTs and the CAMHs teams a number of service development issues during the last year have resulted in anxieties among staff members and a level of mistrust in CHCP management. Within the CAMHs team at the time of interview there was a level of uncertainty about the direction the service was moving in, and the extent to which integration would occur, both between the former child and adolescent teams and also between health and social work as organisations. Some participants voiced concerns about the way the process was managed. For instance:

*I think initially there was a lack of communication and clarity and senior managers didn't carry the workers with them on what their vision was.*

This perceived lack of communication led to a view that changes were being "imposed" on staff:

*I'd say that it's still very top-down management style, where you know, they can obviously listen to you, at the end of the day decisions are made and that's it. And so I don't have a great deal of confidence that, if they don't agree that things will be changed.*

Concerns around participation and consultation during the service development process were also met with scepticism in other service areas. Some of the teams within the SSCD case study

felt they had not been sufficiently consulted about future service development plans. Others were sceptical about the power individuals and teams held in the 'grand scheme' of events:

*There's lots of speak, speak, speak, and you kind of think, how much power have they got? Maybe they have got power at a local level, but there's somebody else who already knows what's going to be happening.*

This again led to feelings that changes were going to be imposed on staff and a view that more communication is needed for staff and further opportunities to contribute to decision making. However, there were distinct differences in the perceptions of staff during this stage of CHCP development that related to the leadership at different levels within their service area. For instance, staff commented that trust in management begins to decline when they are past the level of being "familiar faces", relating back to the earlier point about the importance of personal trust.

Particular difficulties and a relatively high level of mistrust in CHCP management emerged where some of the constituent teams of staff within the SSCD case study felt more disconnected from the CHCP developments and felt very strongly that they had not been kept informed of planned changes:

*You know I said to [manager] that we felt really very undervalued and we felt disrespected because they were putting all these plans... you know, they're putting all these plans together and nobody had actually come at all and told us.*

This had led to high levels of mistrust in management and anxiety among team members:

*We still have this kind of battle on our hands, because if that's how management are treating us, like idiots, then, you know, they're just... they're not being honest at all with us.*

Some of these views and lack of trust have been heightened by the movement of managers around the system during the early days of the CHCP. This has resulted in some service managers being in post for a relatively short time period and has raised anxiety levels as existing relationships between managers and teams break down and have to be re-started with a 'new face':

*That's quite difficult actually because I would say that since there's been a lot of unease. In the last year we've had three managers, you just kind of get used to a manager and they move on and you get another manager and I feel sometimes they don't really know exactly what we do...because you just think, you're just starting to chip away and we say we're here and we do this and we do that and it all changes again anyway.*

Although changes in management have caused considerable concerns for some staff, a number of participants felt that managers in the system had been supportive and had provided answers to the questions they had. Service within the SSCD case study are clearly at a much early stage of integration and service development than the other service areas included here. It will be important to observe and explore how levels of trust develop and fluctuate during the next twelve months as service changes are implemented. The perceived lack of leadership that bridged between these teams and the CHCP has highlighted the importance of a 'middle level' of leadership during times of change.

Within the CAMHS team, leadership roles had emerged within the team that served to reassure staff during periods of uncertainty. A newly created part time Team Leader post for the CAMHS team also served an important role in linking staff views with more senior management and acting as a 'buffer' between these levels of the organisation. The Team Leader was perceived by CAMHS members to be fair, open and responsive to team and individual needs. However, a number of participants questioned the capacity of the part time role in being able to meet the expectations staff had of a team leader. This is a particularly important issue at a time when staff felt there was a need for more intensive service and team development where a full time team leader post would have been more helpful and realistic.

Within our final case study area, the CMHTs, there were also varying degrees of trust in management, again in part related to the level of communication with frontline staff about ongoing service changes, and concerns around future developments. Participants across the three CMHTs all felt that communication between staff 'on the ground' and their immediate line management has been particularly good. Once again the role of team leaders has been crucial in keeping staff informed of ongoing changes and forming a bridge to senior managers. There are clear professional structures and lines of accountability up to the level of team leaders, however the matrix structure of health and social work management above this level was perceived to cause some issues and some staff felt more comfortable with a manager from the same organisational background who had an understanding of structures and professional issues.

Some degree of mistrust had emerged in the CMHTs in relation to more senior CHCP management and, as with other areas, this related to concerns around service developments and perceived difficulties with the consultation process. A major concern across the CMHTs at present is the possibility of the introduction of the Care Management role, perceived by staff to represent a move towards generic workers and an erosion of their professional identity. The majority of participants raised concerns in this area and questioned the need for and evidence supporting the introduction of this model of care. Where staff felt there had not been clear communication of development plans in this area it had created a sense of mistrust:

*I just raise a slight suspicion that we've all been bluffed you know all this thinking about generic workers which, you know, and that kind of raises these concerns.*

There is clearly a need for further communication with staff on this topic in order to tackle the high levels of mistrust and anxieties that are in the system. A related concern was in relation to staff consultation and events. While participants viewed service development days positively as a forum for voicing concerns and being able to ask questions, there was also a level of scepticism about what the outcome of this would be, as one respondent said:

*The Sainsbury's people came round for an away day and staff gave their views and opinions. And there were a lot of views...and there were a lot of problems mentioned. And I don't really know what's happened about that, I don't know who's taken that on board...it can be a bit therapeutic...but then what happens next? And is this stuff just lost?*

Staff clearly valued these opportunities but in order to further develop and sustain trust in service managers there is a need for further feedback from such events and information about decisions that are taken and the reasons behind them. Despite some of these concerns there was also acknowledgement of some of the difficulties faced by service managers:

*The problem is the managers who are putting a lot of these things through, they're not very supportive because it's kind of new to them as well...and this is nothing against the managers. But we're all in this together...some of us with probably mixed feelings.*

Familiarity with managers depending on existing relationships, a professional basis or the level of staff within the organisation, impacted on the level to which staff identified with service managers. This level of identification with managers and levels of trust is also related to the level of integration within the case study area and the impact this had on professional structures

and professional roles within a team. This is discussed further in relation to professional identity within the case studies.

### **Trust in the Organisation**

At this stage of the research it is difficult to make any conclusions about the level of trust in the CHCP as a new organisation. However, in order for a level of support to grow for the vision and agenda of the CHCP a level of trust will be required, as one respondent stated:

*We're having to build in people's confidence in CHCP structures. I have to build people's trust in the direction that CHCPs are going, and that's very hard to do when everything that people want and do on a daily basis...and systems that you actually need to be working nice and easily, and flowing well, to give people the confidence to turn up at their work and deliver, those have all been pretty poorly migrated. And I think my own reflection of the last year, is that I think they changed too much at the one time.*

As the CHCP develops over the next twelve months the research will continue to explore how staff confidence and trust in the organisation grows and fluctuates. In relation to the two parent organisations there were mixed levels of trust. Some staff felt secure in the parent organisation as an employer. However, others had a high level of cynicism due to the "constant change" that occurs across the system. A further key factor affecting levels of trust has been the Pay and Benefits Review in social work and the Agenda for Change process in the NHS which have led to some staff feeling disillusioned and undervalued. It remains to be seen whether this will have a significant impact on the development of the CHCP and the willingness of staff to adopt new models of service delivery. However, in slight contrast to these case studies findings the results of the survey highlighted that respondents remain resilient to the ongoing levels of change across both parent organisations, as illustrated by the following quote:

*Since 1996, change has followed change with no real overall improvement in service, until recently by some accounts, or indeed no opportunity to absorb the lessons of change...Having said this, many of us recognise the need to change, to alter and organise our services in better, more dynamic, joined up ways, but by instalment, not in a wholesale fashion which this current change feels like, already. Change should be a necessary, but positive action.*

This will be an important area to explore further as the CHCP develops, in order to gauge whether staff are able to remain as resilient as the survey would suggest, but also to see how

new service developments and the changes to pay and benefits impact on the level of trust that develops in CHCP management.

## Identity in the CHCP

Within the case studies issues around identity related to two levels: firstly the organisational and CHCP identity, and secondly to professional identity. The main issues relating to each are presented below.

### **Organisational Identity**

The survey findings highlighted that while a strong sense of CHCP identity had formed at the EMT level and with CHCP managers, outwith this group there was still a level of confusion around the role and vision of the CHCP and a partnership identity had not yet formed. This view is also common across the four case study areas with staff still clearly identifying themselves as Social Work or NHS employees:

*I still see myself as NHS, I don't really see myself as being part of a Community Health and Care Partnership just now.*

Some of this organisational identity was related to differences in culture and understanding between health and social work colleagues, and differences in organisational structures, systems and conditions of employment:

*No I think they are quite different. Our ethos is quite different and culture's quite different, how they operate is quite different, the structures are different, the policies and procedures are different.*

A further layer of identity for some staff relates to the city-wide partnerships that exist in some service areas. Staff within LD services still appeared to have a distinct identity from the CHCP, and although staff tended to identify with their employing organisation and immediate team, many also identified themselves with the citywide Glasgow Learning Disabilities Partnership.

However, some staff were beginning to feel part of the CHCP, particularly in those interviews conducted at a later stage (June/July 2007), for instance:

*So in a way I feel as though I'm, I feel I'm part of a bigger picture. I also feel part of the bigger picture with integrated service coming in.*

As discussed in section 4 the process of writing and disseminating the Development Plan 2007-2010 has also begun to increase awareness and understanding of the CHCP across the East.

### **Professional Identity**

When interviewees were asked how they would identify themselves the majority do define themselves according to their profession across all case studies. This strong sense of professional identity resonates with the survey findings presented earlier, but the case studies enabled further unpicking of this trend and a number of issues emerged.

This universally strong sense of professional identity across the case studies was further strengthened wherever staff perceived their identity to be threatened by historical and new service developments. Within LD services staff referred to broader (i.e. not directly related to the CHCP) changes to the social work profession and views that they had become “*expensive administrators*”, leading to frustrations about the capacity that remained for contact with service users and team members. At a time where staff are being asked to invest time and effort in building collaborative relationships this lack of capacity could impinge on the development of the integration agenda. A review of administrative functions is currently ongoing across the CHCP in an effort to address some of these issues. The primary issue for both health and social work colleagues within LD services was the perceived threat to professional identity that had been caused by the integration of health and social care staff.

Although the difficulties that some interviewees recounted were not common to all staff, it did seem that some health staff in particular felt threatened in terms of their identity and role. Some of these views had previously emerged when LD services were originally integrated, a development process led by social work as an organisation which resulted in health staff feeling marginalised and at times isolated. There were some views that clinical roles within the teams had become diluted, however, this is also now perceived by some other participants as staff being less willing to evolve in terms of their core role, preferring their clinical remit in preference to broader care management tasks. It was also the case that connotations relating to the use of the title ‘care manager’ were problematic for some participants, as the role implies that staff become *commissioners* and *organisers* of care rather than *providers* of direct care and some, both health and social work colleagues, felt this took them away from the job they trained to do.

Where staff had been employed from a health or social work background as a Care Manager, professional identity was not perceived to be an area for concern. There are clear implications for service developments across the CHCP of introducing new roles and asking staff to take on new roles and lessons should be learned from the experience of LD services. A number of new service changes and policy responses within LD services have led to a review and strengthening of clinical roles within teams which could address some of these concerns of professional identity. The citywide LD partnership was felt by many to be dominated by social work and that health “*lost its way*”, there is now a view that health is “*coming back*”. It will be important to ensure that the enhancement of clinical roles within the teams is not perceived by other team members as being too protective of individual roles rather than committing to the more integrated ethos of the broader team, although comments from some participants indicate there could be underlying tensions in this area.

Similar challenges and tensions are now being faced within the CMHTs as new service developments within the CHCP begin to take effect. Professional identity was again a major topic of discussion within interviews among staff who felt their role was threatened by current and forthcoming developments. For instance, while many staff accept the ethos of integrated working, their concern lies with the ‘appropriate’ level of integration and the potential introduction of new working models such as care/case management. Some staff feel their “*professionalism is being eroded*” and voiced concerns that these changes would result in all staff having generic roles and losing their specialist skills. This view was not universal and some staff, particularly those newer to the service, were more comfortable with the idea of a care management role. However, concerns were shared by many staff from health and social work. The following quotes illustrate the strength of feeling of CMHT staff:

*So we’ve got [staff group] saying, well, that’s my job, I don’t want to give it to you. So we don’t want it and they don’t want to give it away so what are they playing at here? You know, why can’t we just carry on doing what we’re doing now, because it does work well.*

*I think people will go to nursing for a specific reason and they’ve gathered years and years of experience in nursing, likewise in social work. They go into social work for specific reasons after gaining years of experience from social work and turning everything generic, I think destroys someone’s uniqueness in the provision of care of a certain client group. So I am resoundingly against any ideas of this generic working.*

*So that's kind of difficult, but I do think I've worked really hard to become [a profession] and I'm really proud of being in [profession] and I'm very happy to do what I do and I would hate to think that any of that expertise is being diluted in any way.*

Participants tended to feel that whilst adopting an 'integrated' model to the extent of joint working and co-location was a good idea, this is where the process should stop:

*I'm not saying I disagree with it... I think [they] do a damn good job, but they're trying to blur the boundaries too much and I'm thinking let's just stick to the jobs that we're trained to do.*

There is a role for some further communication, discussion and reassurance from managers within the CHCP in relation to care management as currently rumours are spreading and this is leading to anxiety in the system:

*I just wish that they would come down to the lower level and talk to the team, who's going to be the integrated care manager, what's the actual role of the integrated care manager, there's several versions of it. And who does what and... no doubt it will be wonderful but people are still confused, when people are confused you get a bit afraid...it feeds the fear of people who are still entrenched and don't want to move on and it gives them excuses for not to move on. And again, that filters into the wider groups and, you know.*

These 'rumour mills' could begin to have a negative impact on the teams if this continues, and has the potential to be damaging to the collaborative process.

Within the remaining case studies, CAMHs and SSCD teams, although there was a strong sense of professional identity, this was not an area of major concern as professional roles were not perceived as being threatened. Within the CAMHs team a sense of team identity was developing and close joint working was eased by a "lack of professional rivalry", although the former child and adolescent teams still maintain their own clear identities. Where some anxiety does exist in the CAMHs team relates to uncertainties around the extent of integration planned between the two former teams. Here, although staff would remain within their specialist professional roles, changes could result in working with a different age group and therefore moving outside of the 'boundaries' and identity of their training and experience. However, at the time of interview it was not clear to what extent staff would be expected to work across age groups.

Within the constituent teams of the SSCD services professional identity remained strong, and there was a clear team identity within the different specialist areas. As these services had not yet been integrated or co-located these identities remained stable. There was also a clear sense that these services were specialist and this should not be changed:

*I think some of the difficulty we've had is persuading the powers that be that actually we are not part of generic community services, we are a specialist service, which was delivered in paediatrics and it's a secondary tier service.*

This view was also present at the team level:

*We're quite happy to liaise and work with other teams as much as we can, but we are quite passionate that children should be looked after by [profession].*

It will be important to explore these views as the CHCP develops and as teams are re-organised to see if this has any impact on the willingness of staff to work in a more integrated way. However, this will largely be dependent on any model of service delivery that emerges as Specialist Children's Services become aligned within CHCP management structures. Where staff see their role as quite distinct it could be perceived to hinder collaborative relationships. However, where specialist roles can be maintained and teams co-located this could also positively enhance service delivery by forging closer links with relevant colleagues without the challenges posed to professional identity by greater integration of roles, as seen in LD and CMHT services.

### **Professional Structures**

A common issue to emerge from the case studies, and indeed across the CHCP, has been the impact of the new partnership arrangements on professional structures. Participants talk about the "disruption" to professional structures and the way they have become "very threatened" through the CHCP.

There was some early confusion around how line managers relate to professional leads. This has been a particular issue for some staff who are managed by somebody with whom they could not immediately identify themselves with as they were from a different organisation, i.e. social work staff managed by an NHS employee and vice versa, or from a different professional

background. Staff felt it would be good to have 'greater clarity' around the professional and line management structures and roles. For instance:

*I think that's one of the problems with the CHPs is that actually there has been a real loss of professional staff, actually of any sense of senior management, where do you go with things, what do you do if your having problems? Who is the best person to take a decision about something, about the training etc.*

Where new line management and professional structures were separate there had been some early challenges for staff in obtaining information and advice, particularly in relation to training and development opportunities. For one participant this had involved raising a training opportunity with a line manager, being directed to a professional lead for guidance over the relevance of the course, the professional lead contacting the line manager for approval, and finally the course being approved by the line manager. By this time the deadline for registration had passed and the training opportunity lost. Clearly some of these early issues will be clarified as people adapt to new systems but resolution of these difficulties should be a key development area.

Some staff had managed to maintain existing professional networks within the new structures but others had been lost, as one participant said:

*Well I have to say...one of the unfortunate results of the reorganisation, is that it's broken up a very small professional network.*

Where networks had been maintained they were viewed as an important source of peer support and a way of developing professional knowledge and maintaining a clear sense of professional identity.

For some team members the disruptions to professional structures that have emerged with the CHCP have led to a degree of professional isolation, for instance where a small number or single member of a profession exists within a team:

*I think it's a real, I think that's quite an issue for [profession] actually, that there is not, if you look at the structure of nurses, psychologists, doctors, there is a much clearer structure, or has been in the past because they've got a big critical mass.*

However, some staff felt that even under the 'old system' a professional lead might not have been able to provide clinical guidance specific to a specialist client group so for some staff groups there is an existing general issue around professional support which has been heightened by the development of CHCP structures.

Some respondents did feel that professional and management structures work well for them currently and this was particularly evident in teams where strong team and/or professional leadership existed. Where staff felt they could identify more closely with service managers on a professional basis, it appeared that they felt more supported through the changes and felt more comfortable in voicing concerns. It was also evident in some areas, for instance the CAMHs team, that the existence of a strong professional group within the team meant staff felt more supported and secure during periods of change and anxiety. As one respondent said:

*There's people on the team that don't have a line manager for their profession...and I think it causes them a bit of an anxiety. Whereas I don't have that anxiety and I don't see other [profession] members of the team with the same anxieties.*

In summary, it is clear from these case study findings that professional identity is an important issue for many staff and becomes stronger where staff perceive it is threatened. It will therefore be vital to the progress of the CHCP that these issues are well managed as changes are implemented to ensure that the maintenance of professional identities, and the related boundaries that may impose, does not become a barrier to developing areas of more integrated working.

## Measuring CHCP Performance

As with earlier interviewees the case study participants found CHCP success difficult to define and the majority of responses related directly to improvement in services and quality of care. This emerged from the strong ethos of care that participants demonstrated across their service areas. Box 2 illustrates the main measures of success put forward by case study participants.

## **Box 2: Expectations and measures of CHCP success**

### **For patients and service users:**

- Clear pathways of care – seamless, harmonious services
- More 'one-stop-shop' approaches to service delivery
- Satisfaction for service users and patients

### **For services:**

- Reduced waiting lists and waiting times
- Improved auditing and monitoring of services
- Developing appropriate measures of success

### **For the organisational systems:**

- Improved communication and reduced duplication
- Clarification of service boundaries, and improved understanding of professional roles
- Clear management and professional structures in place
- Job satisfaction

Box 2 aims to provide an overview of the main measures of success articulated by case study participants. Many service-specific measures were also identified and these will be presented within individual case study reports for each of the four services.

## 6 Conclusions

Having discussed at length the principles and processes associated with moving towards an integrated CHCP model, this final section provides some concluding thoughts in relation to the four research objectives, reflects on other salient aspects of the work beyond these objectives, provides an account of the ways in which the research will be disseminated, and sets out how the work will be continued in Phase II.

### Objective 1 - Measures of Performance

We set out to improve our understanding of the underlying issues of partnership (inter-agency) management with a view to determining key measures of effective partnership management that can enhance the performance of Glasgow's health and social care services. In so doing, we sought to combine perceptual measures with objective measures of effectiveness.

In the findings section, we have separated out issues of performance in terms of both Hudson et al's (2000) and Dowling et al's (2004) frameworks. We have sought to take purely subjective (perceptual) measures such as individuals' perceptions of their own role and effectiveness, and to begin to create a baseline of data (through the surveys) and to gather evidence against published frameworks. As we have noted, there is a dearth of literature on the issue of network/partnership performance, due largely to the problems associated with measuring processes and their performance. We have also noted the **still early stage of change** in the overall development process and intended **period of stability** during the first year of the CHCP. Nonetheless, what we can conclude at this stage in the research is that:

1. There is an acknowledgement of the **need for and potential benefits of partnership working**, and a view that health and social care *should* be able to work in partnership.
2. There is, however, a notable degree of **scepticism** about the reality of partnership working given the high visibility of organisational and professional boundaries. This is of particular importance given the majority of staff have prior experience of working in partnership between health and social care (as well as with other agencies).
3. There is a **limited sense of interdependence** between health and social care staff. This is a key issue because if there is no perceived need to work together (albeit there might be benefits to doing so), if the obstacles to partnership are not readily overcome,

and there is no compelling need to work together, it is possible staff will simply work independently but with a veneer of partnership (rhetoric rather than reality). This is discussed further below.

4. There is an ideological commitment to partnership working, but **reward structures** seem not to be compatible with partnership objectives. Thus, when under pressure (as is the case most of the time), staff will increasingly prioritise those things that will enhance their career and individual performance. At present, these things are not in line with partnership working. Again, this further undermines the notion of interdependence.
5. **Organisational change** does increase pressure on staff and there is an acceptance of this amongst CHCP staff. Staff seem to be resilient in terms of accepting a degree of ambiguity/uncertainty and pressure. However, they are aware it compromises their ability to do their job. In performance terms, there are two issues: (a) the fact that change does compromise performance; and (b) the fact that this is accepted over the long term. This is not a CHCP-specific issue, but one endemic to health and social care. What is a negative in terms of performance is in some respects a positive in terms of organisational change! What is also notable is that there is some variability in the capacity for change across different service areas, particularly as a result of the difficulties in social work staffing levels.
6. **Trust** was found to be higher amongst peers (at all levels) than it was across the different levels of the organisation. Much of this can be put down to the fact that senior managers have had little time to demonstrate achievement and thus limited opportunity to gain trust from others based on evidence of competence, knowledge, professionalism, consistency and fairness. On the other hand, given services have been co-delivered by health and social care (though mostly not integrated) for some time, there is a history of relationships between peers at their respective organisational levels that has created trust based on knowledge, professionalism, expertise and social interaction. Trust at this level may, however, be undermined by the fact that some of the structural changes have fragmented or deconstructed individuals' professional networks and has left them with both a sense of isolation and a concern that they will not have those networks to draw on in their day to day work, and may as a result be less effective.
7. **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 is likely to pitch one service area against another and is likely

to highlight the tensions between trusting colleagues and engaging in the political exchanges that characterise organisations. At present, there is no 'risk' as such and trust has 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.

8. In terms of **establishing clear and robust partnership frameworks**, we found that there is a degree of confusion about the roles of various committees – although this is becoming clearer over time – and that the disparities between health and social care in terms of pay, as well as the differences in terms of culture, are serving to highlight differences rather than highlight complementarities between the organisations.
9. Related to point 8, is the need to be clear about the **type of integration** that is envisaged. There is a degree of uncertainty about the end point of structural integration in terms of the implications for referral patterns, staff roles (e.g. care management) and the language associated with the delivery of front line care. With already mixed messages circulating in relation to the impact of integration, resistance to integration may arise.
10. **Co-location** was found in some cases to have '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 is not yet clear to *all* staff whether service users benefit directly as a result of co-location.
11. **Partnership capacity** is needed not just during the period of change, 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 or opportunity 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. Partnerships in this setting may be effective, but not necessarily efficient.
12. Related to the issues of capacity and change is the fact that CHCP staff are interested in **evidence**. There is a desire to be honest about the benefits and costs of partnership

working, and to be realistic about what might be achieved in 1, 3 or 5 years time in relation to services, service users and staff. Gathering evidence and appraising the costs will be an integral part of creating a climate of openness and trust that might be sustained and might further support ongoing change.

13. Finally, in relation to capacity, 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 part of the CHCP. Change and organisational development activities will need to take account of these differing capabilities and capacity for change.

Whilst the report suggests that there is a good degree of acceptance of the principle and objectives of partnerships, a key issue is the **limited sense of interdependence** between health and social care which, in our view, raises some fundamental issues for the CHCP. Where organisations need one another, it is easier to identify respective strengths, weaknesses, resource complementarities and thus collective gain through collaboration (sometimes referred to as collaborative advantage, see for example Huxham and Vangen, 2005). It is often the case, however, where collaboration is mandated (e.g. through Government policy) that the rationale from the point of view of staff becomes blurred and politicised. Thus, in the absence of a clear sense of mutual need and mutual benefit, the focus by default becomes one of perceived efficiencies and areas of service duplication. In the minds of staff, this is interpreted as battle-grounds around overlapping territories, loss of power, potentially reduced resources and the erosion of professional boundaries – typical responses within a process of change.

A core issue here is the actual **focus of integration** and performance in the minds of staff and policy makers. It seems the case (so far at least) that much of the emphasis is on integrating systems and staff, i.e. structural change, but that the changes are not being viewed primarily, or from the outset, from the point of view of the service user. As a consequence, staff will talk about the fact that partnership working 'should' result in improved services, but so far, this is understood only in terms of bringing multi-professional perspectives to a problem where alternative professional perspectives, languages and priorities come to the fore. Rethinking CHCP provision 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.

A related issue concerns information on which to make performance and service user-centred decisions. Much of the information required is held in fragmented and often inaccessible

locations. There is clearly a great deal of effort being made by the Planning and Health Improvement Team in addressing this problem, but the task is sizeable and it will take some time before data are available to support discussions about service performance and improvement. The absence of consistent and meaningful data, however, makes it difficult for discussions to move beyond professional boundaries to services per se and service user-related information.

Also in relation to performance is the 'undercurrent' or *informal grapevine*. All the 'actors' within the CHCP system are in effect engaged in a process of 'sense making'. Many are actively seeking explanations or predictions for the future of their role, their team and the partnership more broadly. The stories they hear about successes or failures, will be readily communicated and will over time create a narrative around the effectiveness (or otherwise) of the CHCP. Given the policy context in which CHCPs have been formed, there will be two narratives: the ground level narrative and the managerial narrative or the internal and the outward facing narrative. Whilst this is inevitable in organisations, and indeed part of the accepted norm of the organisation / policy interface, a more fundamental issue – for the organisation at least – is whether the narrative from the point of view of management is dislocated from the narrative amongst staff.

We have witnessed during the course of this research, a considerable degree of confusion amongst staff at an operational level within the CHCP, and many are actively seeking to 'make sense' of their new world by speaking to those who are held up as examples (i.e. Learning Disabilities). The stories told by LD staff will have a legitimacy that visions and statements from management are unlikely to have. In other words, because people trust best information from those they know (or as a proxy, who function at 'their level'), greater credence will be given to the LD staff's positive and negative perceptions of partnership effectiveness. Given the mixed messages emerging from LD services that have filtered through to other service areas, this is an important consideration for CHCP managers. Considerable effort will be needed to 'counter' negative perspectives, most effectively by way of short term gains and the broadcasting of 'good news' stories and partnership successes.

There is, with this approach, an inherent tension. Short-term success may not necessarily take the organisation along the pathway required for long-term success. In other words, short term gains may be at the expense of longer term gains.

As noted earlier, there was (and continues at this point in time) to be an openness to change, a belief (in the face of limited evidence) that partnerships *should* yield improvements for service

user. There was also, however, a clear view the **organisational barriers** were visible, and many were of the view that although there is a will for partnerships, there may not be a 'smooth' way. In our view, this is one of the most important, imminent and long-term aspects of the change process on which the EMT might need to provide ongoing, concerted effort. Managing 'culture' and attitudes is particularly difficult and there are no ready-made short cuts or quick fix solutions. What can be done in addition to ongoing development activities, is to ensure that performance management and staff review incentivises, recognises and rewards behaviours that contribute to the 'new' partnership culture rather than to those that simply maintain the status quo (in effect serving as a barrier to change). In "The Prince", Machiavelli wrote: "*All innovators make enemies of those who prospered under the old order, and receive only lukewarm support from those who will prosper under the new*". It is perhaps helpful to bear this in mind when considering the next steps. It is safer to assume opposition and lukewarm support than to assume or place too much emphasis on engendering widespread enthusiasm for change.

**Performance** is an area fraught with difficulty. Managers (and policy makers) tend to manage what can be measured (Smith 2005). Sadly, that which is measurable is not always meaningful and the measures themselves are often crude. What is more difficult for CHCPs is that if overall success is measured in terms of population health improvement, then it is essential that there are means of measuring this that are available in the short term. More importantly, however, there needs to be some means of managing or influencing those parts of the CHCP and the wider system that have most immediate impact upon, or who hold key performance information relating to, health improvement.

It has been clear to us that a particular difficulty for CHCPs is around the area of managing **health improvement** (HI). At present, the health improvement 'philosophy' is expected to permeate the CHCP and influence people's mindsets so that service planning and delivery is somehow informed by the longer-term health improvement objectives. However, in a highly pressurised, task driven environment, this is unlikely to succeed. There are no specific incentives for services to respond to the changes required by overall health improvement objectives, neither are there penalties for failing to achieve improvements, not least because these are difficult to measure. As such, it is likely that those charged with responsibility for raising the HI profile, adjusting mindsets and so forth, will feel as though they are 'pushing water up a hill'. There are several issues here:

1. Health improvement is long term – staff at middle and front line levels think short(er) term, as required by the pressures of service delivery;

2. Health improvement targets are achieved through collective effort – there are still major organisational boundaries and professional boundaries that need to be overcome before collective effort can be consistently secured;
3. There are a number of performance targets being discussed that in effect focus on individual service areas and may mean staff focus on ‘their own patch’ rather than on the collective effort across service areas that ultimately contributes to health improvement.

A further difficulty is that of amassing **evidence** of ‘where partnership has worked’ in the past. As noted above, although in LD much progress has been made in developing a shared understanding of, and language around, service delivery, there remains limited recall of improved practice that has resulted in partnership success. A key issue for the CHCP is, therefore, to manage ongoing expectations in relation to (a) the change process itself; and (b) what the CHCP might realistically achieve.

## Objective 2 – Coordination and Consistency

Secondly, we sought to examine the connection between local partnerships and the wider organisations within which they are embedded, giving particular attention to issues of coordination and consistency, i.e. ensuring coherent strategy, policy and direction across the organisation. In short we were looking to identify the determinants of the effective management processes that are under the control of the partnership as opposed to the control of the larger organisational setting.

As we have discussed, a particular issue in relation to coordination and consistency arises from the significant differences between health and social care as organisations. Co-location in particular has brought both similarities and differences between these organisations to the forefront of day-to-day life. Differences arise from language, professional backgrounds and hierarchies, as well as pay and conditions, public holidays, working hours and IT systems. These tangible and intangible symbols, practices and norms are at odds with the notion of coordination and consistency and prove to be a real source of difficulty for staff. Not surprisingly, when IT systems are incompatible and working hours or holidays vary, it proves problematic for staff to think of their work in the context of an integrated partnership. Quite clearly these issues are beyond the scope of the CHCP to influence – indeed, they are at the core of NHS/Social Care/Educational integration in Scotland and England - yet they have a fundamental impact on the potential effectiveness and performance of the partnership system. It would seem to staff and to members of the team, that these dimensions of the respective partner organisations will serve as a constant countervailing influence on the efforts of EMT

members and partnership champions and need to be factored into the creation of change agendas and partnership objectives otherwise unrealistic goals and cultural shifts will be set and disappointment will ensue.

### Objective 3 – Trust among Partnership Players

Drawing from pre-existing work on partnerships, it was important to explore in depth the precise nature and development of trust among partnership players (individuals and organisations).

The results in terms of trust are positive at this stage. Trust in peers is higher than has been viewed in other public sector organisations. The high level of trust identified among colleagues is a real asset for the CHCP and should be viewed appropriately as an important resource for the partnership process. Whilst staff may be undecided about senior management (and to a lesser extent line management), there has been only a minority view that either senior or line management is considered untrustworthy. In this regard, staff are open to persuasion and management has an opportunity to win the confidence and trust of staff. The key issue therefore is in the way in which managers perform (and are perceived to perform) in relation to (a) shaping expectations; (b) fulfilling expectations; (c) communicating both positive and negative elements of organisational change; (d) developing staff capacity for change; and (e) responding to issues raised during consultation. As work in a related area suggests (Beaumont et al, 2005) the process of consultation itself raises expectations amongst staff over and above the content of that consultation, as they expect some form of return on their investment of time and energy in the consultation process.

A further area of ongoing consideration is that of trust amongst senior management. The early stages of CHCP formation have been largely benign in that EMT members have had a common aim and common set of pressures to which they must respond. However, as the development plan takes effect, and as competing priorities appear in terms of demand on resources, profile of issues on the EMT agenda etc, the deep core values of individuals and their political alliances will play out increasingly in the day to day EMT relationships.

Much of our work has involved observing the EMT on a weekly basis. In doing so, we have developed the view that the team has integrated quickly and effectively, with members readily securing a degree of confidence in one another's abilities and a certainty that on the whole the team want the same thing for the CHCP and its constituent services. This in itself is not something to be underestimated. Such cohesion and commonality of view is both difficult to achieve, and often proves illusive to organisations in other settings.

There are some emerging dynamics, however, that will be important in determining whether this cohesion is maintained. Firstly, the group has evolved and enlarged and now comprises people not involved at the start of the CHCP formation. This change in membership may result in perceptions of an 'inner sanctum' where there is a core of staff who have developed a close working relationship and a group who are more peripheral. This in turn can effect perceived importance of contribution to discussion, and can (unintentionally) create barriers to the 'newer' members of the group.

A second challenge is that of ensuring that urgent matters do not drive out those that are important. The agenda for change is sizeable, and ongoing issues of performance, working with elected members and so forth, will inevitably create pressure points. The EMT may find it helpful to review agendas for previous meetings and to note where items have dropped off the agenda in preference to other issues that may be urgent but not necessarily any more important. As we move into Phase II, our recordings of EMT meetings will review agendas, minutes and observations to see if certain issues are regularly sidelined, such that original timescales are not met, renewed timescales not made, and 'owners' of those agenda items run the risk of feeling marginalised as the CHCP develops.

#### Objective 4 – Sustainability of Trust

Related to objective 3, we determined to examine the nature, basis and sustainability of trust between partners in the context of the successful delivery of service outcomes. In short, we were raising the possibility of whether there is a trade-off relationship between a successful partnership process and successful delivery of health outcomes.

The research team have noted throughout the project, that staff within the East CHCP have been uncommonly open to external scrutiny, have an appetite to learn from others' experience, and have a willingness and capacity for reflexivity that is not often found within organisations. This cultural characteristic is not only refreshing to researchers but is extremely important in terms of managing and effecting change throughout the CHCP. Given the size of the CHCP, the composition of the two partner organisations and the fluid environment in which the CHCP must form its own identity and working practices, it is unsurprising that a proportion of staff are unclear about what the CHCP might ultimately mean for them and for their service users. The fact that even within this somewhat ambiguous climate staff are remaining positive to any degree about 'yet more change' is testament to the calibre of staff and to the energy and vision of the EMT.

Moreover, the research team have observed a considerable degree of 'best practice' in relation to managing change. There is a high degree of trust and agreement about partnership working at the EMT level that provides a good basis on which to manage change. There seems to be a clear agenda for change, an understanding of the complexity of the process, a willingness to consider where the changes may be less effective, and in terms of leading by example, the EMT are showing that they are willing to commit time and energy to ensuring that the CHCP is a success. They do so despite the organisational differences (between health and social care) that have a direct effect on their own working environment as well as that of their staff. The development plan has been devised through wide consultation, and staff and service users have had the opportunity to feed into that process.

There remains a considerable degree of change still to take effect, and the Organisational Development (OD) work already planned represents only a part of that process. A key challenge at this stage is to ensure that the process of partnership does not overtake or obscure the focus on the end result / service user-related outcomes. Major organisational change is draining for staff as well as potentially engaging, but it is easy for the politics and processes to gain a life of their own. Placing some of Dowling's service user outcomes at the centre of OD activities, and underpinning these with the CHCP's service objectives and performance measures will allow a focus on what needs to be done in relation to services and service users, and can highlight gaps in performance information and the ways in which staff behaviours might be incentivised in relation to these new performance objectives.

## Dissemination

A core objective of the GCPH, and a stated objective of this research from the outset, has been to provide the CHCP with direct and focused feedback on the research findings. This has only been possible as the analysis has been completed. To date, we have produced:

- A briefing note on the history and principles of partnership working (available at <http://www.gcph.co.uk>)
- Interim report to the GCPH (November 2006)
- GCPH seminar presentation (November 2006)
- Feedback to CHCP EMT members during project review meetings
- Health Organisation Research Network Workshop (February 2007)
- Feedback to Children's Services Management Team of case study work

- Pate J, Fischbacher M and Mackinnon J (2007) Improving Public Health in Scotland: Countervailing Pillars of Partnership and Profession, *Clinician in Management*, Forthcoming (Accepted for publication subject to minor changes). (ISSN 0965-5751)
- Fischbacher, M; Smith, D.; Mackinnon, J. and Pate, J. (2008) "Partnership & Change" for *International Journal of Public Sector Management*, Special Issue, (under review) ISSN: 0951-3558.
- Health Organisation Research Network Workshop, forthcoming (November 2007)

In addition, it has been agreed that we will provide direct input to the EMT and operational team meetings, as well as to staff workshops through:

- oral presentation of findings;
- summary reports of the findings to each of the CHCP groups;
- contributing to the design of Organisational Development activities, drawing directly on the findings of the research; and
- providing an intranet based newsletter updating all staff on the findings of Phase I, and the plans for Phase II. This will be designed in collaboration with the East CHCP's communications officer.

## Research Phase II

As the interviews for Phase I were completed, only 4 months had passed since the launch of the CHCP Development Plan. Even as we write, many of the issues noted in this report are filtering through agendas on the respective CHCP groups/committees. In reality, the CHCP has had very little time to embed any real, lasting change (a consistent feature of organisational change however revolutionary it may be). The focus for Phase II of the research is, therefore, to continue to monitor progress in relation to the objectives above, in particular:

- comparing survey results from the first survey with one to be conducted in Spring 2008 (to include comparison with available MORI survey data);
- examining evidence around partnership success, particularly within the context of the service case studies;
- exploring the rationale behind, and impact of perspectives associated with the medical and social model; and
- examining the views and contribution of independent contractors to the CHCP.

A further objective of the work in Phase II is to ensure that findings from Phase I are disseminated effectively throughout the CHCP. We will therefore build on the approaches outlined above, and provide ongoing feedback as each of the stages of Phase II are completed so that change interventions can draw on current CHCP data.

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