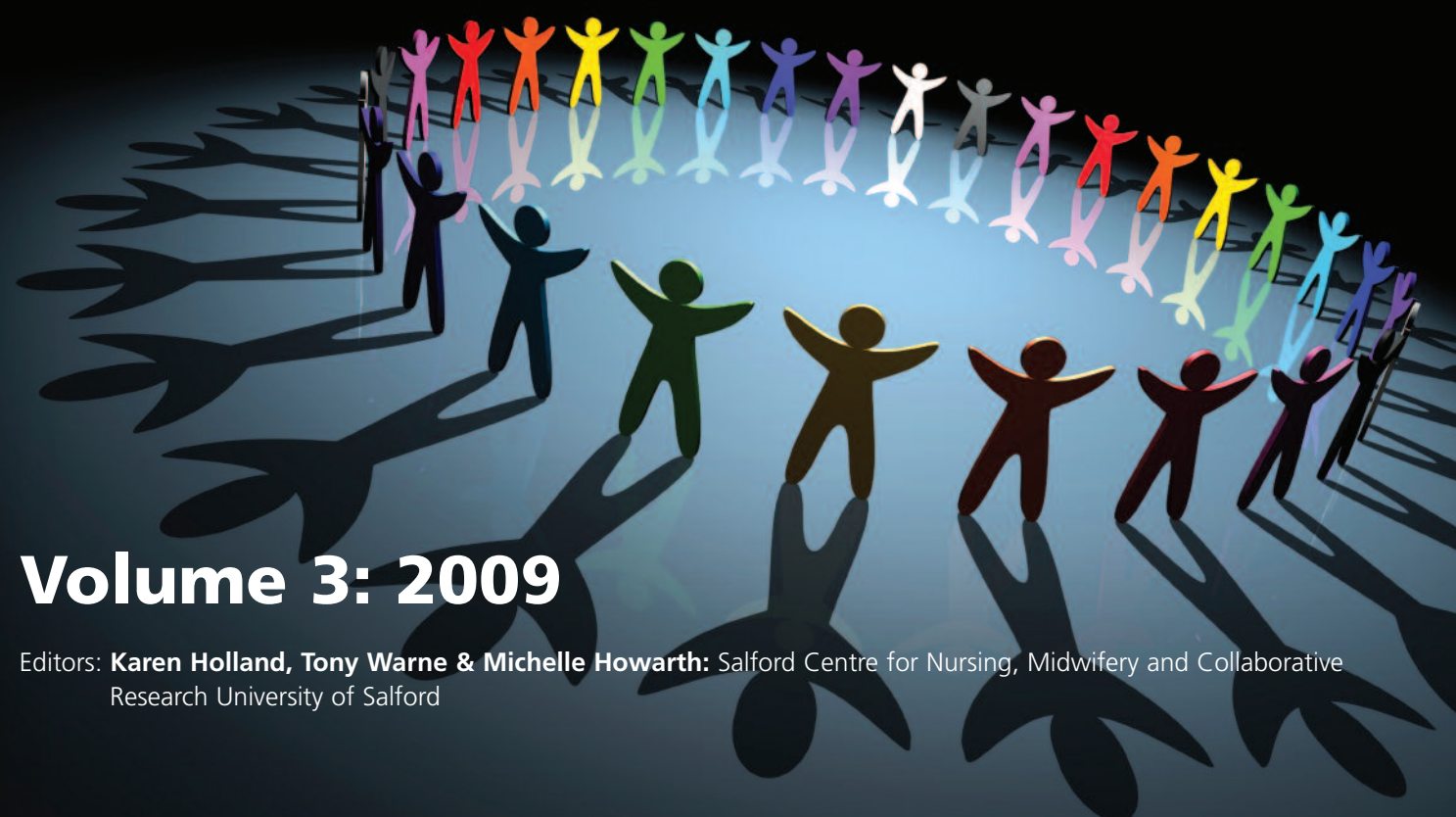URBANregeneration
making a difference

Explicating the role of partnerships in changing the health and well-being of local communities in urban regeneration areas:

an evaluation of the Warnwarth Conceptual Framework for Partnership Evaluation

A Case Study Approach

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The Project Context

Introduction

This case study evaluation is one of three outputs from a project: Explicating the role of partnerships in changing the health and well-being of local communities, one of a number of projects in a larger Higher Education Funding Council Strategic Development Fund project (HEFCE) entitled: Urban Regeneration: Making a Difference. This was a collaborative venture between Manchester Metropolitan University, Northumbria University, University of Salford and University of Central Lancashire. Bradford University was an affiliated partner.

Health and Well-Being Theme

The North of England has some of the worst health profiles in the UK, with startling inequalities in the health experience of different population groups as defined by geographical and social group. Relative proportions of deaths from cancer, heart disease and stroke in particular, have been rising in recent years. Rates of long-standing physical and mental health are also high compared with other parts of the country.
The North of England has some of the worst health profiles in the UK, with startling inequalities in the health experience of different population groups as defined by geographical and social group. Relative proportions of deaths from cancer, heart disease and stroke in particular, have been rising in recent years. Rates of long-standing physical and mental health are also high compared with other parts of the country.

These patterns are manifestations of the degree of well-being in the community, which is affected by a wide range of factors, including housing, poverty, transport, employment etc, covering the whole spectrum of regeneration issues. Availability for work is a natural consequence of health and well-being, with some parts of the North having amongst the highest figures of worklessness in the UK.

Whilst the public sector is the mainstream provider of support, through the National Health Service and local authorities, the non-statutory sector plays a vital complementary role and is critical to sustaining the welfare of some of the most vulnerable communities and sections of the population. This includes charities and not-for-profit organisations such as housing associations. It is a diverse and fragmented sector with an ability to be highly responsive to new ideas.

Effective cross-sector working is fundamental to the challenge of meeting the needs of vulnerable populations and working towards the inclusion of marginalised groups. Universities have a key role to play in this process, yet this form of knowledge transfer is only in its infancy, with huge potential for development.

The NHS and local authorities are heavily dependent on the higher education sector as a source of professionally qualified people and as a resource for further professional development and research and evaluation. This is complemented by practical, action-research in a number of HEIs, which is focused on the needs of communities of practice.

The Health theme identified 4 important areas which link health to regeneration:

- *Health, employment and well-being, including the social and economic dimensions of regeneration;*
- *Ageing and disability, including the health and social care dimensions of regeneration;*
- *Enabling environments, including the physical and cultural dimensions of regeneration;*
- *Public health and primary care, including health inequalities.*

In addition, a core focus across all of the projects will be on increasing the skill and knowledge level of those working in health and well-being regeneration. (From (http://regennorth.co.uk)

The Project: Explicating the role of partnerships in changing the health and well-being of local communities

It is clear that concepts of partnership and collaboration underpin the successful implementation of urban regeneration initiatives. What is less clear is how partnership working impacts upon the health and well-being aspects of urban regeneration. Evaluations of outcomes are limited, and little comprehensive information is available as to the extent of any such activities across the North West and North East regions. This project sought to examine the issues in relation to these and to develop a framework for supporting the analysis of effective partnership working.

Key aims of the project

There were four main aims of the project:

1. A scoping and mapping exercise to develop a profile of community health and well-being needs and associated neighbourhood renewal activity in Salford and the northwest, and in Newcastle and the northeast

2. A review of the literature and development of a conceptual framework for partnership evaluation

3. Evaluation of the framework in action through a series of case studies of partnership working in designated urban regeneration areas

4. Determine the key factors in effective partnership working

Conclusion

The project was in itself a recognition of the need for partnership working between Universities in order to maximise the value of shared knowledge and experience in addressing a common aim. It was also an opportunity to engage with local communities in urban regeneration areas to identify their needs and experiences in relation to their health and well-being and also determine a way in which effective partnership working could be assured.

Chapter 1: Partnership Working in Health and Wellbeing Regeneration Initiatives - An evaluation of the framework

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Summary

Partnership working in urban regeneration heath and wellbeing contexts have been inadequately evaluated as a consequence of poorly articulated conceptualisations of partnership working. The Warnwarth conceptual framework was developed to address this evaluative weakness. The framework is predicated on the notion, of the 'good enough' partnership. This chapter examines the Warnwarth framework within illuminative evaluations of urban regeneration health and wellbeing partnerships.

In a form of bricolage, a series of interrelated case studies explored the eight key aspects of the 'good enough' partnership that make up the Warnwarth framework. The case studies focused on partnerships that are concerned with promoting health and wellbeing within communities. Data were drawn from a range of participants within the case studies, including managers, service users, educationalists and practitioners. The findings showed that the Warnwarth Framework could be applied across a wide range of organisational contexts. It helped facilitate exploration of partnership working within health and wellbeing regeneration initiatives.

1. Partnership Working in Health and Wellbeing Regeneration Initiatives.

Introduction

Innovative methods of raising public health awareness have been at the forefront of UK health and social care. Recent policy guidance (DH 1999; 2000a; 2000b; 2002; 2004; 2006) signalled the UK governments' vision for healthier communities. As a result, the focus of public health moved toward a community 'hands on' approach predicated on partnership working between the NHS, local authorities and independent agencies, with particular investment being made for the regeneration of urban communities. Currently, local regeneration initiatives concerning health and wellbeing have been at the vanguard of community and public health development. Essential to the success of such initiatives is achieving effective partnership working .This chapter focuses on the development of a framework used to evaluate the role of partnership working in health and wellbeing initiatives in urban regeneration areas.

The Relationship between Regeneration and Wellbeing

In their report, 'Action for Sustainability', the North West Development Agency (NWDA 2000) set a series of long term strategic goals for the North West Region. This included the need to develop safe, and healthy communities in a region which uses resources wisely and that which attracts high employment with an appropriate infrastructure. The operational challenge faced by the NWDA (2000) was to ensure that partnership working was effective and sustainable for the North West region to develop. They assert that:

"Mainstreaming sustainable development principles at policy and strategy level, together with robust application of these principles at programme and project delivery level are vital to the sustainability of the North West. Policy-makers and practitioners must continue to work together to push the boundaries of understanding to ensure that the relevance of sustainability to all North West activity is clearly identified and progressed" (NWDA 2000 pg 9)

The state of public health in the North West of the UK has witnessed increasingly negative public health statistics. For example, those living in the North West have a greater chance of developing Coronary Heart Disease (CHD), Cancers, and have some of the worst mental health problems in England. Despite a recent decrease in the number of deaths from coronary heart disease in the North West, current statistics indicate that 220 per 100,000 people in the North West dies from CHD (British Heart Foundation 2006). Cancer incidence in the North West is also amongst the highest in England. (Shack et al, 2007). In relation to mental health, the North West has the largest number of people misusing drugs and the biggest number of people with severe and enduring mental health issues.

Public Health and Communities under Strain

An increased older population adds to these worrying public health statistics. The result is often local communities experience considerable socio-economic and public health strain. This is manifest through the numbers of carers needed, home support services and the economic and employment stability of the community. Such health and social inequalities need to be addressed to reduce the incidence of cancers, mental health and CHD in the region and facilitate a prosperous region within which communities can expect to live a healthier, safer life. Since the mid 1990s, a number of urban regeneration initiatives have been undertaken, with a focus on health and wellbeing. The partnerships involved however, were multi-agency and often complex. Many of the outcomes of these partnership approaches have not been examined. There was an evaluative need to explore the extent of partnership working within health and wellbeing regeneration initiatives, and what each partnership had been able to achieve.

2. The Project: Urban Regeneration: Making a Difference

Tackling this problem the Higher Education Funding Council in England funded five Higher Education Institutions' under the umbrella title of 'Urban Regeneration: Making a Difference'. This initiative had two key aims based on the inter-disciplinary collaboration and the development of long term strategic alliances between core Universities through knowledge transfer to meet the needs of business and the community.

The contextual focus was on urban regeneration. Prosecuting the wider aims involved a number of smaller sub-projects around four key areas of activity: community cohesion, enterprise, crime and health and wellbeing.

One of the sub-projects: 'explicating the role of partnerships in changing the health and wellbeing of communities in urban regeneration areas' aimed to evaluate partnership working through a number of different case studies in urban regeneration areas .To undertake this work however required an initial analysis of the key literature to develop a conceptual framework with which the case studies could be analysed and subsequently inform the wider project outcomes. This Chapter will discuss the development and early application of the Warnwarth Framework which was designed to explicate the role of health and wellbeing partnerships in the urban regeneration case sites.

3. Conceptualising Regeneration within Health and Wellbeing Partnerships.

Nationally, the health and social care agencies and Primary Care Trusts (PCT's) faced a number of public health concerns. Addressing this problem required collaboration between many agencies, partners across health, social care, housing, built environment, local authorities and the voluntary sector. As a result, local NHS Trusts have adapted policies to help secure and grow sustainable communities that are healthier and safer. A range of partnerships has developed over time, each with varying agendas, priorities and partners.

Booth (2005) argues that urban regeneration has generally been described as being 'market-led' and that this characterisation' fails to embrace the complexities reflected in the development of urban regeneration over the past 25 years. Although there is a wealth of evidence about partnership working and sustainability (Glasby 2006), most of these partnerships have been measured by their successful ability to foster joint ventures which embrace an array of complex attributes, which may also fuel further ambiguity about the partnership construct and its goals.

Our review explored the extent of this partnership working for health and wellbeing within urban regeneration developments. A structured search strategy was developed to capture previous studies on the extent of partnership working in urban regeneration areas.

Partnership working has been defined in numerous ways which provided a good starting point from which to view the evidence base. This plethora of definitions however, was not without its complications. To develop a framework that truly assessed partnership working meant that the concepts needed to be grounded in operational practices helping in order to validate the framework within familiar constructs and discourses.

Additionally, as the crux of the review was to locate evidence about partnership working for health and wellbeing in urban regeneration, the concept of health and wellbeing was also explored. However, locating a consensus on the definition of health and wellbeing proved difficult due to the many abstract conceptualisations available. The World Health Organisations (WHO 1998) definition suggested that health and wellbeing is:

"A state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity" …*"So health and wellbeing are often used synonymously. Health and wellbeing can be described in terms of function (physical, mental and social) and feeling (physical, mental and social). When there is an impairment of function (which may or may not be related to active on-going disease), this can be termed disability".*

However, this definition has long been viewed as being contentious. Indeed, several critics (Saracci 1997, MacDonald 2005) have refused to subscribe to the WHO's definition arguing that "it incorporates total wellbeing under the concept of health", and that "the definition is not a relational claim between the various parameters of total wellbeing and a more limited range of components identified as health. Rather, it is an identity claim such that an individual is not truly healthy unless they have complete wellbeing. In this instance, the idealized condition of complete wellbeing and the concept of health are synonymous" (MacDonald 2005). As such, many question the relationship between health and wellbeing an example being that a person could be chronically ill yet spiritually happy:

"health and happiness distinct experiences and their relationship is neither fixed nor constant" (Saraicci 1997 p1409).

The concept of urban regeneration exacerbates this conceptual swampland by calling on the dual notions of 'health' and 'wellbeing' almost interchangeably. In the context of urban regeneration, health is usually linked to the social and community outcomes. Sampson (2003 p53) asserted that:

"Health-related problems are strongly associated with the social characteristics of communities and neighbourhoods. We need to treat community contexts as important units of analysis in their own right, which in turn calls for new measurement strategies as well as theoretical frameworks that do not simply treat the neighbourhood as a "trait" of the individual".

It appears that this remains a contentious issue as it is still assumed a strong relationship between health the community and wellbeing. Given the problems operationalising the definition, it is not surprising that 'context' is importantly seen as the influencing common denominator in attempts to define urban regeneration. Within this study, Robert and Sykes (2000) definition of urban regeneration was used in because it embraces the complexities involved by asserting that it is:

"a comprehensive and integrated vision and action which leads to the resolution of (urban) problems and which seeks to bring out a lasting improvement in the economic, physical, social and environmental condition of an area that has been subject to change" (Roberts & Sykes 2000, p17).

Based on the limited contemporary evaluations and the copious (and often somewhat spurious) evidence so far, defining the key elements of partnership working within health and wellbeing proved to be problematic. With no clear operational definitions, it became evident to the team that any partnership evaluation tool would need to embrace and harness such complexities so as to provide enough flexibility in use so as to facilitate a 'representative' account of partnership working.

4. The Warnwarth Framework

Atkinson (1999) asserts that there is no fixed descriptor or definition of partnership working. The complexities involved render any attempt at definition as futile. However, for the purpose of our review, we used the term 'partnership' to encompass all types and levels of collaboration. In doing so, we took the opportunity to adopt a more pragmatic approach which allows the term partnership to embrace a range of attributes and constructs. Partnerships therefore reflected a broad range of joint ventures and activities. Whilst the range of activities within partnerships is recognised as diverse, attempts to undertake too much at any given time can be deleterious for the partnership (Long & Arnold 1995, Atkinson 1999, Powell & Darling 2006). As such, the team needed to be mindful of the pre-requisite notions attributed to successful partnership working and develop a framework which both fitted an acceptable definition and also embraced diversity. Partnerships need to reflect changing contexts and roles (Warne & Howarth 2009).

In our review therefore, we drew on the previous work of Warne (1999) and Macaulay (1963) to conceptualise partnerships as being:

"A relationship that exists on a continuum characterised by permanence and transition (Macaulay 1963 pg 27) where at any one time, the location and effectiveness if the partnership is likely to be dependent upon a number of dependent, independent and interdependent factors (Warne 1999).
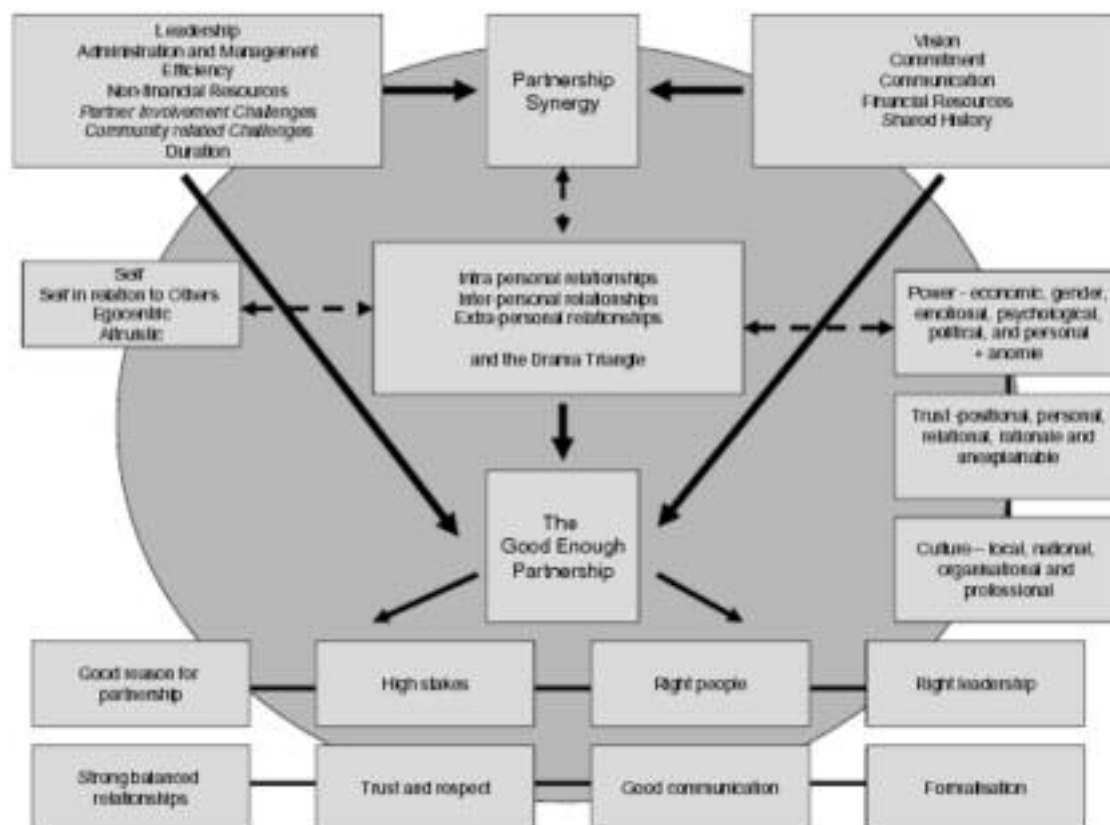
The 'Good Enough' Partnership

In the context of our review we were interested in understanding how partnerships facilitate health and wellbeing within and across communities. Moreover, we were acutely aware of the inherent tensions within partnerships and the influence this has on the process and outcomes. These tensions are interlinked and often reflect the partnership 'synergy'. For example, we found that 'leadership', 'administration', 'non-financial resources' coupled with 'partner involvement challenges' and the 'community relation challenges' are just some aspects that influence partnership working. In addition other prominent elements include the vision, commitment, financial resources and shared history. Combined with wider factors such as the prevailing culture, politics and power relationship, there is a convincing argument that all these elements subjectively 'feed' a partnership. These often difficult to measure subjective factors add to the complexity.

We argue that these complex reciprocal processes within the context of partnership working could best be described as being situated within a 'good enough' relationship. Taken together, the steps towards a good enough partnership have been based on Winnicotts (1965) psychoanalytic idea of the 'good enough mother' and viewed this in the ordinary colloquial way of 'is it good enough to do the job?' To answer this, eight key characteristics of the 'good enough partnership' need to be considered. These are the right reasons, high stakes, right people, right leadership, strong balanced relationships, trust and respect, good communication and formalisation.

In determining the right reasons for a partnership, a shared vision, a strong desire to work in a partnership coupled with and easily understood and agreed life span and goals might indicate the rationale for the partnership. High stakes suggests that there are usually compelling reasons for undertaking a partnership, in which there is a visible contribution around finance and resources and an agreed partnership outcome. Right people, are those who have the most appropriate skills and attributes and are able to empower others and agree to equal representativness. The right leadership consists of many traits and descriptors are not exhaustive. What is evident is the need for strong clear lines of accountability and leadership which fosters openness and respect with other partner members. Akin to the need for strong leadership is the notion that relationships play a pivotal role in determining how partnerships develop. Although thought to be challenging and time consuming, there is a need to ensure that relationships reflect reciprocal arrangements which endorse a well managed, and organisationally supported approach to partnership

working. An authentic 'values in action' approach is essential to cement a trusting and respectful relationship. All partner members need to feel valued and respected at all levels within the organisation. However, without good communication to support and bolster a partnership, efforts to develop any sustainable relationships may be limited from the outset. Effective communication processes are arguably one of the most important elements of successful partnership working. Without this partnerships will struggle to sustain developmental momentum. Finally, the way in which partnerships are formalised suggests that even in the embryonic stages of development, partners need to consider governance systems which may support the decision making processes. Due to the fluid nature of many partnerships, it is essential that these arrangements be monitored and adapted on a regular basis. Good formalisation processes provide managerial leverage to support longevity and sustainability of the partnership. Given the context of urban regeneration in heath and wellbeing – this sustainability is of increased importance.

The Warnwarth framework embraced the complexities of the good enough partnership working alongside the concept of urban regeneration and health and wellbeing. The Warnwarth conceptual framework provided a partnership evaluation approach which was used to undertake case study evaluations of a range of different current health and wellbeing regeneration projects. It provided "a framework upon which theories and issues that develop around and from the case studies could eventually be integrated into an analytically coherent whole" (Warne & Howarth 2009 pg 50). (See Figure 1: The Warnwarth Conceptual Framework)

Figure 1: The Warnwarth Conceptual Framework.

Methodology

To identify whether the Warnwarth Framework helped determine the 'good enough' partnership, an illuminative evaluation approach was undertaken. Illuminative evaluation is not a discreet methodological package but a general research strategy (Parlett and Hamilton 1976). This approach lends itself to a range of methods that may be used in a study which should follow from the decisions in each case as to the most appropriate techniques. This means that the problem being investigated dictate the method. This triangulation of methods ensures that a rich source of data is tapped thus providing a more complete picture of the partnership. In this way, researchers engaged in evaluating the various partnerships were encouraged to act as bricoleurs, whereby, they become adapt at using a range of methods to support their enquiry and thus ensure that the methods follow the problem. Put simply, bricoleurs have been described as being:

*"Jack of all trades or a kind of do it yourself person who deploys whatever strategies, methods, or empirical materials are at hand…
…if new tools or techniques have to be invented or pieced together, then the researcher will do this"* (Denzin and Lincoln 2000p4)

Originally the case site researchers were encouraged to act as bricoleur's when developing their local approach to case study evaluations. A group discussion held after the case sites had been evaluated using the Warnwarth framework explored the extent to which the case site evaluators applied the 'good enough' concepts and how far they adopted the position of bricoleur. Understanding this provided a unique insight into the utility of the Warnwarth framework in determining the extent of partnership working in each of the case sites. Data relating to its usefulness can help ensure a validated framework capable of being transferred to other contexts.

In total, five case sites (see Chapters 2 - 6) applied the framework to gauge the partnership working. Each site was ideally placed within an urban regeneration area and had focussed on different population and community needs. These included an older people partnership, a New Deal partnership and a regeneration 'wellbeing' community project partnership. All five sites were encouraged to use the framework and report on its applicability and usefulness. In addition, the flexibility of the framework can be readily adapted to any partnership context because it lends itself to a range of data collection methods. In this way, the researchers acted as bricoleurs in the way they used the framework and adapted it to their own partnership contexts. A discussion group was held with the case study sites where they were asked to outline how they used the Warnwarth framework and their perceptions about its utility.

The Messiness of Real World Partnerships in Regeneration.

The group discussions facilitated frank exchanges about the framework based on their experiences. The case study researchers indicated that the Warnwarth framework had helped them to unpick the many elements of partnership working. The framework had been used to support the development of an interview schedule in one site. In this example, the research team used the key elements of the 'good enough' partnership to guide their interview and probe the respondents for in-depth details. Membership, roles, communication and involvement in the partnership were explored and whist there are no data yet available to discern the level of partnership working in this case, the way in which the framework was used to explicate this knowledge is

heartening and suggests an element of success. In particular the researchers remarked on the framework's flexibility and applicability to the context and suggested that the tool was helpful in disclosing the key elements of partnership working in the case site.

One case site suggested that the Warnwarth framework acknowledges the messiness of real world partnership working and as such helped the researchers capture the complexities and interrelatedness of partnership working. This particular case used the 8 elements of the 'good enough' partnership to frame their analysis and in doing so, argued that this contextualised the process, but neglected the outcomes. They used the 'good enough' concept as a spring board from which they were able to discern whether the 'partnership had been good enough to do the job and achieve its aim'. The team looked beyond what had been developed and explored how the services had developed through partnership working. Using Dowling et al (2004) as a starting point, this case team examined the outcomes that were achieved as a consequence of the partnership. This resonates with the partnership synergy described in the Warnwarth framework. The outcomes described by the team and how these were achieved appear to relate to the subjective phenomena of a partnership which are often hard to capture. This included, for example, the 'drama triangle', which embraces many of the subjective elements of partnership working:

"The scripts for these dramas arise from how individuals, groups and organisations add or respond to the turbulence of 'everyday' organisational life. These dramas are characterised by relationships that use and misuse of power, whether this be economic, gender, psychological,

relationships where trust, positional, personal rationale is present or absent, and which are culturally defined by resistance to or acquiescence of the prevailing local, national, organisational and professional norms. Partnership working therefore, can be experienced as a messy reality despite the often authoritative rhetoric and guidance that is readily available and used in policy documents" (Warne & Howarth 2009,pg 43).

So in this example, whilst the Warnwarth framework didn't explicitly relate to outcomes per se, it did incite this response and subsequent exploration of outcomes.

Fitting the Mould.

A strength of the Warnwarth framework is its ability to be relevant across a wide variety of contexts. This was highlighted by the case site examples through which the Warnwarth framework was readily applied to a range of settings. Arguably this was also due to the researchers acting as bricoleurs whom by adopting this approach were able to use a more flexible approach. It is also acknowledged that there is a number of existing partnership evaluation tools that have originated from business and health which further support the needs for a flexible approach. Indeed, our original working concepts outlined a partnership as a continuum characterised by permanence and transition. This suggests that the lack of consensus about the definition of partnership has ironically provided a platform for developing a flexible evaluation tool.

Sketching out the determinants of a flexible partnership is not new. Many have distinguished the importance of flexibility in an effective partnership. A case in point is Druce & Harmer (2004) whose exploration of the key elements of effective partnerships highlighted the need for flexibility advising that this could improve and help build ownership. In addition, the fluidity of the partnership – whilst promoting a flexible and realistic approach to successful working may also deter some; causing ambiguity about the nature and goals of the partnership. For example, Reich (2000) asserts that:

"the rules of the game' for public–private partnerships are fluid and ambiguous, and constructing an effective partnership requires substantial effort and risk, as no single formula exists" (Reich 2000 p618).

This would suggest therefore a paradox when determining a 'flexible' or fluid approach to partnership working. From the beginning, many would suggest that process and outcome need to be considered and that in doing so, the partnership may then be better able to survive against the influx of unpredictability.

5. A Paradigm Shift from Process to Outcome?

In his paper exploring collaborative context and policy, Bob Hudson (2007) suggests that there is a move towards a more performance managed arrangements based on the notion of outcomes. Concerns about whether process or outcome should be measured within a partnership are resonant in the literature. Atkinson and Maxwell (2007) describe multi-agency outcomes-based performance measurement model used in Children's Services Planning to monitor agreed outcomes.

This method aligns itself with performance management and the authors argued that this allowed for the identification of new measurable indicators that could be used to assess needs. In particular, they assert that this involved a:

"paradigm shift from collecting activity data on an organization by organization basis to managing information on a multi-agency basis using indicators based on outcomes as part of an integrated performance measurement system" (Atkinson & Maxwell 2007 p 15).

In our study, the use of outcome measures as a method of evaluating the partnership was drawn on by two of the case sites. They remarked on how the Warnwarth framework had helped evaluate the partnership process, but cautioned that there was also a perceived gap in relation to the outcome of the partnership. Originally, the review team considered process 'versus' outcome as a key element of partnership working. This led us to question what partnership working does and/or provides and it was through this process that we noted a difference between 'provision' and 'doing'. In our original discussion we agreed that the term 'do' denotes partnership internal function as opposed to external outputs and that 'provision' suggests some form of output. So, in relation to 'output' we questioned how we would ascertain that the act of partnership working was solely responsible for any outcome. For example, what outcome would have occurred if partnership working wasn't evident? We also questioned what the partnership 'does'. For example, function, doing and outcomes have a common denominator. Enabling services to join a partnership could be seen as a function, process or outcome and the difference between the two remains

ambiguous. As such, we believed that process and outcome were intertwined, inseparable and entangling. This symbiotic relationship is not explicit in the Warnwarth framework, although when used the framework has prompted the exploration of the importance of 'what and whose outcome' might be across different constituencies. In health and wellbeing partnerships, there are some obvious opportunities for high levels of congruence with outcomes. Individual health and wellbeing clearly feeds into and impact upon the health and wellbeing of a family, and community. Other examples of such congruence might be found in the overall partnership achieving local and national service standard targets and a objectives.

6. Implications for Public Sector Management.

There have been significant developments in Urban Regeneration designed to support health and wellbeing in local communities. Successful partnerships that embrace the diversity of such activity are essential for communities to flourish. The processes involved in these partnerships have rarely been explored due to the plethora of partnership definitions and the fluidity of Regeneration work. This chapter provides a framework which may be used to unpick the nuances of community participation and cohesions within partnerships with particular attention on the health and wellbeing elements of community development.

The common issues that face public sector managers when determining regeneration partnerships have the potential to incite problems in the embryonic stages of partnership working. Using the Warnwarth

Framework can support managers to develop partnerships which may then be later evaluated against the same criteria by considering the dynamics of engagement involved at intra, inter and extra-interpersonal levels. (Holland, Warne & Howarth 2008)

Conclusion:

As a team, we identified evidence which illustrated complexities inherent in developing a conceptual partnership framework. The term 'framework' denotes some form of structure or construction – paradoxically, such rigidity had the potential to deter its utility – particularly in relation to partnership 'synergy'. We therefore adopted an alternative stance, and designed a partnership conceptual framework able to embrace to the need for change within any given environment. Based on the case site evaluations, we argue that the flexibility resulting from the Warnwarth framework application in partnership evaluations enables aspects of partnership working to be revealed, acknowledged and responded to in a way previously difficult to achieve.

Practical Implications

The Warnwarth framework provides a conceptual anchor for those involved in undertaking evaluations involving various forms of partnerships working. Used in the context of health and social care partnerships, the usefulness of the framework can be transposed to other settings involving multi-stakeholder collaborative working.

Originality and Value

Increasingly, the health and wellbeing of a community is being recognised as a key concern for regeneration activity. This framework can support future partnership developments within this context.

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Notes

Chapter 2: Explicating the role of partnerships in Northumberland FISHNETS

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Summary

Northumberland FISHNETS is a partnership that was developed in response to a government initiative known as Partnerships for Older People (POPPs). Within the POPPs programme a total of 29 local authorities, their health and third sector partners (voluntary and private sector organisations) were funded to set up innovative pilot projects that aimed to develop preventative strategies for older people within localities.

Northumberland FISHNETS aims to keep older people FIT, INVOLVED, SAFE and HEALTHY, through investment in sustainable community NETWORKS. The services that have been developed under the auspices of FISHNETS address health, social and environmental factors to support older people to their maintain independence and enhance their quality of life. A key objective of this initiative is the promotion of well being through the reduction of falls and related injury in the older population. Falls have significant consequences for older people none-the-less being serious injury, fracture, loss of confidence to participate in usual social activities and loss of independence. By reducing falls, serious injury requiring hospital treatment and emergency hospital admission can be avoided.

A comprehensive falls prevention programme is now available across Northumberland County including universal primary prevention and targeted interventions for those most at risk of falls. A unique feature of these services is the high level of collaboration between older people and providers in statutory, for-profit and not-for-profit organisations. This has resulted in wide ranging provision including campaigns to raise public awareness of the benefits of exercise and falls prevention, community rehabilitation team intervention, falls prevention exercise programmes in leisure centres, community based exercise and interest programmes, and home improvement through handyman and telecare services. The general perception of these interventions arising through interviews with service users is that they promote physical well-being, improve social inclusion, make homes safer and foster independence in later life.

Northumberland FISHNETS has achieved success in achieving its aims, which would not have been possible without the commitment and collaboration of partnership members. There is general agreement across service commissioners, service providers and older people that they wish to see it continue and expand into the future. However, issues about medium and long term funding add uncertainty to the future. Whatever the future, Northumberland FISHNETS has created a legacy of partnership working between older people and service providers, and the knowledge that preventative approaches to the particular circumstances of old and advanced old age have the potential to improve quality of life.

Introduction

This Chapter focuses on describing the Northumberland FISHNETS partnership and articulating the experience of service planning and change that has resulted from partnership working. This is based on discussions with partners and a documentary analysis of minutes, project reports, service agreements between partners and relevant policy and practice literature.

The partnership delivers a countywide preventative programme, in a locality that is rich in its diversity. There are large areas of rural countryside with small villages/hamlets, sea-side towns and semi-urban districts in the South East where more than half of the County's population live. Within these localities affluent communities contrast with those that fall within the 10% most disadvantaged in England, as identified through the index of Multiple Deprivation. In response to the issues which arise in the deprived areas physical, social and economic regeneration programmes have been developed to revitalise communities and meet need.

Diversity is also reflected in health indices which are marked by contrast across the County and are indicative of post-industrial deprivation, rural isolation and poverty. Added to this rich tapestry of diversity is health and social care service provision which varies across the County, with many people in rural areas living long distances from the towns where building-based services are located.

It is this countywide diversity that presented challenges to the success of the FISHNETS partnership to achieve its aims to provide equitable and accessible services across the County as well as services that are relevant to local communities. The report therefore commences with a discussion of Northumberland County and its older population, the users of FISHNETS services, as a back drop to the main discussion of the FISHNETS partnership. The report concludes with an analysis of what the FISHNETS partnership brought to the County in its mission, at district level, to take forward holistic area based regeneration plans to transform the life experience of all living within Northumberland communities.

Northumberland County

Northumberland is a large rural county in North East England, which contains areas of outstanding natural beauty, and extensive areas of coastline and forest, with the majority of the population living in urban settlements. These settlements are diverse and have developed different roles. There are 12 main towns which provide a range of shopping, community and employment facilities. These towns are Alnwick, Amble, Ashington, Bedlington, Berwick upon Tweed, Blyth, Cramlington, Haltwhistle, Hexham, Morpeth, Ponteland and Prudhoe. There are 11 smaller centres within the catchments of these larger towns which have developed as local service centres - Allendale, Belford, Bellingham, Hadston, Haydon Bridge, Rothbury, Seahouses, Widdrington Station, Wooler, Corbridge and Seaton Delaval. Beyond these are more than 200 villages with fewer than 500 residents, containing limited local facilities.

More than half of the population of approximately 311,300 residents (Nomis Official Market Statistics, 2005) live in the urban South East, an area that covers less than 5% of the County's total land area. Most of Northumberland's large towns are located in this area.

Whilst there are some wealthy communities living in high quality environments in the County, there are also significant areas of deprivation where educational attainment is poor and unemployment is over twice the national average. Limited job opportunities, low expectations, poor housing and health, high levels of crime, drug abuse and an invasive culture of dependency compound the cycle of disadvantage.

These factors contribute to Northumberland's population experiencing considerably worse health than the England and Wales average.

National statistics indicate that 14 Northumberland wards are in the 10% of the most disadvantaged in England. Of these, 12 are located in the South East of the county where the worst deprivation, however it is measured, occurs.

Councils in the South East are addressing deprivation issues through co-ordinated strategic and holistic neighbourhood renewal and community planning. Initiatives such as Wansbeck LIFE focus on area based housing-led regeneration as a lead that also provide enterprise and work opportunities to local communities (see Appendix 1 for further details of key strategy documents).

This approach to regeneration is in keeping with 'Better Health, Fairer Health', the new strategy for 21st century health and well being in North East England which has recently been launched (see Appendix 2) to address these issues of deprivation and inequality. It sets out a 25 year vision for the North East to have the best and fairest health and well-being, and to be recognised for its outstanding and sustainable quality of life. One theme of the Strategy is later life, which the older people of Northumberland contributed to through consultation as the Strategy was developed.

The older population and service provision

Forty per cent of the population of Northumberland are over the age of 50 and this is rapidly changing. It is predicted that 48.4% of the County's population will be over the age of 50 by 2021 (ONS, 2004). Over the same period there will be a sharp increase in the proportion of people aged 85 and over, which is expected to increase from 7,000 to 11,000. Whilst these demographic changes reflect national and international demographic trends that are largely due to an increase in life expectancy, migration to and from the County is also having a significant effect on the balance within Northumberland's population. Many young people choose to move away whereas the County is a favoured destination for commuters and for older people who choose to relocate there as they reach or approach retirement.

Population ageing is unequally distributed across the County. In some localities the pace of ageing is advancing faster than others. It is predicted that by 2009 Berwick-upon-Tweed and in 2016 Alnwick district will have more than 50% of the population aged over 50. Regardless of the variation witnessed within the County other projections indicate that population ageing across the County exceeds that of the English average. Hence, the implications of a changing population will encountered earlier in Northumberland than in other parts of the country.

In recognition of this population change Northumberland Strategic Partnership (NSP) state that "Public bodies, community organisations and private bodies offering goods and services used by older people will all need to adjust to these changes." (NSP, 2007, p.4). All services anticipate that the projected demographic changes bring with it changing expectations of later life and advanced old age, and will lead to substantial increases in the number of older people in need of care.

Expectations of old age change across the life span and this is acknowledged in national policy (see Appendix 3) and locally by NSP. In the NSP strategy for the older population distinction is made between three groups of older people/phases of later life and the public service goals for each group/phase:

• **older workers** – people over 50 who work or are seeking work. The primary goal for this group of people is to ensure that they are able to stay in work for as long as they wish and if they lose their jobs for whatever reason they have opportunities to return to employment.

• **third agers** – people who have retired from work and can reorganise their lives around leisure, family responsibilities, non-vocational education and voluntary work. The key goals for this group are to ensure that educational and leisure opportunities exist and that services support people to maintain their health and fitness to remain in this phase of later life for as long as possible.

• **older people in need of care** – people whose lives are substantially affected by long-term illness or disability. The key goals for this group are to support people to remain independent and able to participate in community life.

These groups are qualitatively different; the differences reflecting the experience of the individual, not their chronological age. Drawing this distinction within older population is important because it opens up new possibilities for services to be structured in such a way that they enable older people to continue for as long as possible in the first two phases, older workers and third agers, thereby reducing the time that older people live in the final phase, in need of care. This is not suggesting that problems associated with ageing, including mobility problems and increasing dependence for the routine tasks of living in the community, will not exist, they will, and will continue to do so.

This strategy seeks to delay the final phase and minimise the time that an individual lives in that phase. This may also delay the time before services witness the predicted significant increase in older people requiring long term care.

Fulfilling the public service goals described above will require considerable change in the way that services are configured and delivered across the County. Historically, services have focused on treatment and provision of care. With the agenda detailed by the NSP there will be an emphasis on preventative and rehabilitative approaches to the needs and problems of old age.

This will require the development of new services that foster engagement with health, fitness and social inclusion related activities. These changes will need to take account of local conditions – in the South and South East of the County a significant proportion of older people live on low fixed incomes and experience all of the detrimental effects of financial deprivation.

Whereas, in rural areas the declining, ageing agricultural workforce experience all the consequences of isolation and erosion of rural services and amenities such as schools, shops, public houses, banks, post offices.

Historically services have been largely centralised within urban conurbations. Rural dwellers in west and northern localities can live long distances from towns and this can enhance the difficulties that they experience in accessing building-based services.

This discussion provides a broad overview of the challenges of moving to a preventative and rehabilitative agenda within Northumberland. It is within this policy and service planning framework that FISHNETS has emerged. The complexities that are integral to such whole system change, which is at the heart of the vision that was borne with FISHNETS, is consistent with the strategic direction of NSP. It is within this context that FISHNETS brings a focus to the issues and concerns of older people living in Northumberland.

Northumberland FISHNETS

Northumberland FISHNETS was developed by a partnership that was led by Northumberland Care Trust which comprised of organisations within the public, not-for-profit and for-profit sectors. The key driver that drew the partners together was to develop a proposal for an old age preventative programme in Northumberland to respond to the opportunity for funding from a government initiative, the Partnerships for Older People Programme (POPPs). Key partners included District and County Councils, Northumberland Age Concern, RoSPA, Council for Voluntary Services, Independent Sector Providers, Supporting People, Home Improvement Agency, Northumbria University and Newcastle University.

When the bid was successful the partnership was reorganised to enable the structural arrangements within FISHNETS to achieve a balance between ongoing development of the FISHNETS vision for Northumberland County and implementation of the agreed plan of work. Effectively this resulted in the formation of a Partnership Board (OPPB) that provides strategic direction and governance for FISHNETS and operational task groups that develop and manage the FISHNETS programme of work (see figure 1 on the next page).

The partners that are represented on OPPB include Northumberland Care Trust (this initially included Director of Social Care and County Wide Services, Head of Provider services – Older People Services), FISHNETS project manager and older people who brought with them the experience of living later life in Northumberland and a wealth of skills derived from occupational and voluntary work throughout their life.

OPPB convenes monthly, providing a forum for Board members to maintain regular communication with each other, ongoing scrutiny of service delivery and decision-making to ensure that decision are timely to meet the ambitious targets that were predetermined in the FISHNETS proposal to the Department of Health.

Operationally, FISHNETS is delivered through six linked task groups. Each task group is comprised of partner organisations that are committed to achievement of the particular goals of that group. For example, the home improvement task group includes representatives from Blyth Valley Care (handyperson and telecare service providers), Northumberland Stars (handyperson provider), Home Improvement Agency, District Council members, Supporting People managers and members of OPPB with a particular interest in the development of home improvement services.

The wide ranging partnerships that exist within FISHNETS is represented in figure 1. By structuring partnerships around operational imperatives individual task group members are mutually interdependent, working in collaboration to meet service targets. By working together to achieve a shared vision for the older population by focusing on task group outcomes unifies and commits members to the partnership. This is particularly important because task group membership does change to reflect the nature of the programme of work that has to be achieved.

FISHNETS PARTNERSHIPS

Home Environment
Blyth Valley Care
Northumberland Stars
OPPB
Home Empowerment Agency
District Council Housing Departments
    Blyth Valley Housing
Supporting People

Communication, Publicity & Events
Northumberland Care Trust – Health Improvement Officers
Leisure Centres
Voluntary Sector
Local Health Care Providers – GP, District nurses
                                        Health Trainers
                                        Consultancies (head massage)
Warm Zone   Yoga, Salsa dancing)
Age Concern
Home Improvement Agency

Universities
Northumberland Care Trust
Northumbria Healthcare NHS Trust
Older People Research Groups

Education & Accreditation
Anchor
Age Concern
Jennie Johnson Housing
Wansbeck District Council
Milecastle Housing
Independent Providers for long term care
Newcastle College
Northumberland Care Alliance
Northumberland County Blind Association
Sight Matters
R.O.S.P.A.

Activities and Lifestyle
Age Concern
Leisure Centres –North Country leisure
        - Leisure Northumberland
        - Castle Morpeth

Northumberland Care Trust
Directorate of Social Care &
County wide services

FISHNETS
OPPB

Northumberland
County Council

Community Involvement
Voluntary Groups
Parish Councils
Women's Institute
Community Development Network
FISHNETs reference groups
Sheltered Housing Providers
Care Home Providers
Centre for Voluntary Services

Intermediate Care
Northumberland Care Trust
North East Ambulance Service
Acute Trust – Northumbria Health Care
Age Concern
G.P's
Pharmacies   } Link
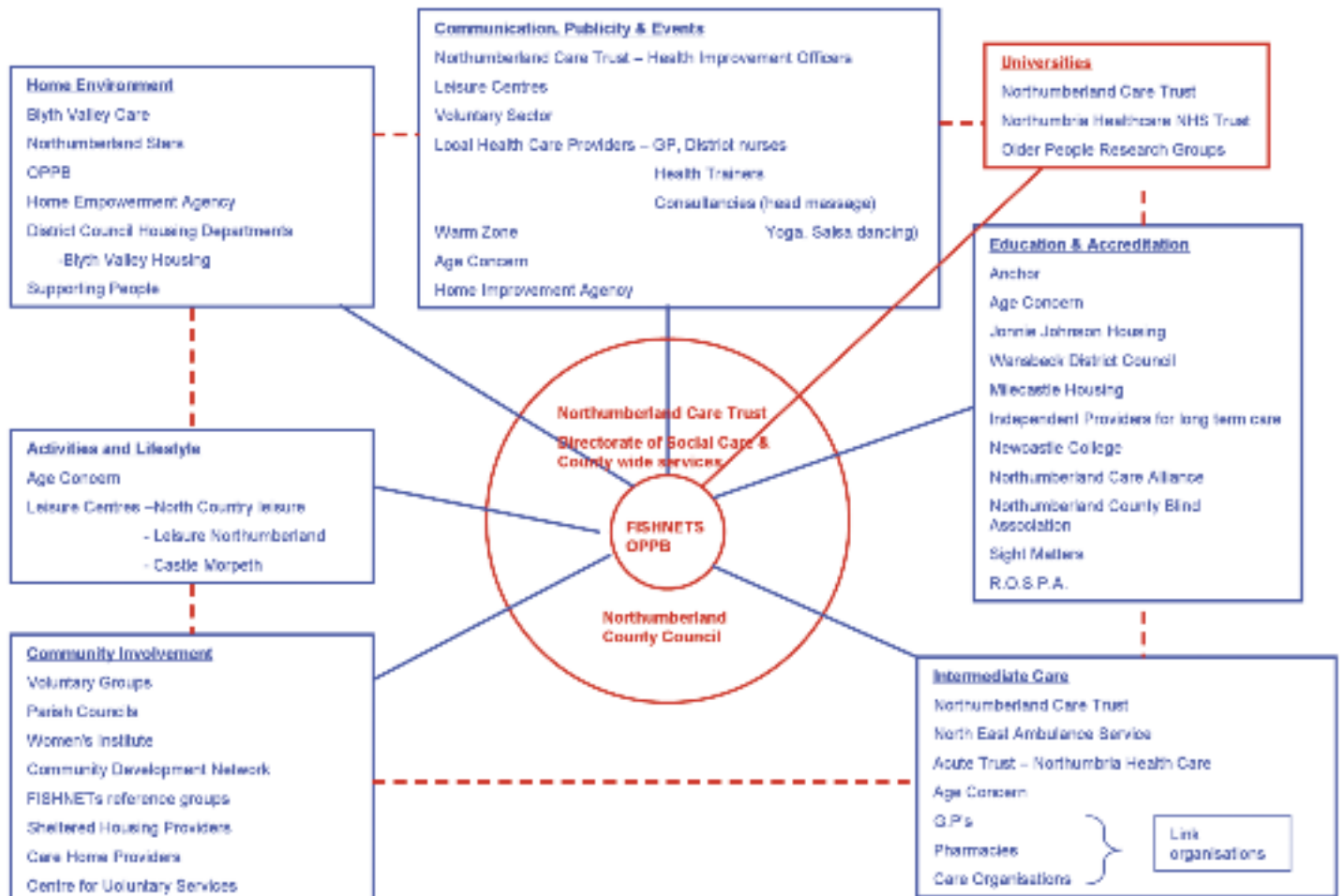Care Organisations   organisations

Figure 1: Partnership arrangements within Northumberland FISHNETS

The FISHNETS task groups are:

Community involvement

Focus of the task group activities: in addition to older people membership of OPPB, community development work focuses on engaging older people in FISHNETS programmes. There is a particular emphasis on 'hard to reach groups' to reduce social exclusion and enhance awareness of and access to the range of preventative services across health, social care and housing agencies. A key strand of this programme of activities is the implementation of the 'Community Chest' which is a fund for the establishment of community activities that promote and enhance inclusion of the older population in social and community activities.

Selective outcomes achieved by December 2007: Approaching £70,000 has been allocated from the Community Chest fund supporting local groups such as church halls committees and friendship clubs to provide physical activities and social engagement programmes.

Education and accreditation

Focus of the task group activities: this group focuses on raising levels of knowledge of fitness, involvement, safety and health and access to networks of support and information, whilst also raising awareness of falls, fractures and osteoporosis through targeted training. Different aspects of the programme are geared to meeting the varying requirements of older people, their carers and those who support or work with them. A key objective is training older people to undertake peer support and mentoring roles within physical activities and lifestyle programmes.

Accreditation schemes establish good practice across the whole system of community health services, care management and community matrons, housing and support providers, care homes, home care and day care and local community groups in regular contact with older people.

Selective outcomes achieved by December 2007: Home care, day centre, sheltered housing, care home staff, handyman and rehabilitation officers across statutory, voluntary, for-profit and not-for-profit organizations (n = 1,935) have participated in the following training programmes:

• Falls Prevention

• Low Vision

• Introduction to Dementia

• Dementia Person Centred Care

• Podiatry

• Train the TrainerSeated Armchair Training

• NVQ Level 2 in Exercise & Fitness

• Nutrition and Assessment in Older People

• Medication in Older People

• BTEC Level 2 in Dementia

469 older people have completed training programmes including Falls Prevention (n = 254) and Low Vision Training (n = 135).

Currently the numbers of services having completed or in the process of accreditation are as follows:

Care homes with respite	86
Sheltered Housing	76
Home Care organisations	16
Day Centres	42
Total services completing accreditation	220

Home Environment

Focus of the task group activities: the Home Improvement Agency coordinates a comprehensive home environment assessment service to assess risks, with advice and interventions linked to fire prevention, crime prevention, fuel economy, heating and insulation, aids and minor work. The existing handyperson scheme has been expanded county wide, and tailored packages of equipment and assistive technology has been made available to augment care.

Selective outcomes achieved by December 2007: Pre- Fishnets only 3 district council areas, Blyth Valley, Berwick and Wansbeck had Handy person schemes in place. In year 1 of the project a contract was awarded, through a limited tendering process, to Northumberland Stars to provide services in the Alnwick area and it was also agreed that FISHNETS would take over funding responsibility for the Berwick contract. In year 2 similar contracts were awarded to provide Stars services in Tynedale and Castle Morpeth. These services have proved extremely popular with the older people of Northumberland and statistics gathered through the recently developed benchmarking tool indicate an 'excellent' satisfaction rating with the services which alongside the completion of 1484 Home safety checks give some indication of the benefit of these initiatives.

Physical activity and lifestyle

Focus of the task group activities: exercise and lifestyle initiatives have been implemented to provide a range of programmes to enable and sustain personally relevant exercise including Tai Chi. Resources are mobilized to assist the most at risk groups of older people to participate in physical activity.

Selective outcomes achieved by December 2007: Through the injection of funding from the FISHNETS project the opportunities for older people to access activities has increased significantly at all levels of ability. It is estimated that approaching 3000 older people are accessing activities, ranging from gentle seated exercise and Tai Chi to line dancing and kick boxing. Although the emphasis has been placed on physical activity these new groups are also benefiting from information sharing and demonstrations of health improvement initiatives including healthy eating. This substantial increase in provision has been facilitated by the training of 32 new Extend exercise leaders, alongside the sourcing and coordination of equipment and instructors for various other sessions such as kick boxing, salsa dancing and new age kurling.

Intermediate care

Focus of the task group activities: development of integrated case management systems, based on the Unique Care Model has been used to proactively seek out and refer those at most risk. Community Rehabilitation Teams have been enhanced and expanded to address the rehabilitative aspects of prevention.

Selective outcomes achieved by December 2007: The intermediate care element of this project concentrated mainly on the development of an enhanced and cohesive falls pathway. Prior to the FISHNETS project there had been segmented and inequitable provision across the county, with the rural north and west being disadvantaged. FISHNETS funding has increased the staffing levels in these 2 areas allowing the development of specialist falls services.

The introduction of the 5 question Cryer assessment tool has opened up the referral system to a wider audience including ambulance crews and self referrers.

A new level of intervention has also been introduced into the falls pathway delivering 12 week programmes of specialist falls prevention classes provided through appropriately trained leisure centre staff, which lengthens the time period for support available to fallers from 10 to 22 weeks, thereby increasing their potential to achieve optimum rehabilitation.

Service data indicates that over 1000 older people have gone through the Falls Pathway to date with local evaluation data yielding evidence of improved functional ability and increase Falls Efficacy levels.

Communication and events

Focus of the task group activities: communication and events has been adopted to ensure the projects whole system impact and to facilitate awareness of and access to programmes across communities. This has been achieved through a communications strategy that involves use of multi-media resources, older people's networks, and intergenerational activities.

Selective outcomes achieved by December 2007: To date 11 Young at Heart and 8 Falls Fairs have taken place with almost 1600 older people attending and receiving information on subjects as diverse as oral hygiene and cavity wall insulation. The FISHNETS website, www.northumberlandfishnets.org has also been developed.

Is Northumberland FISHNETS the Good enough partnership?

In the UK, policy rhetoric and guidance has been predicated on concepts of multi-professional working, collaborative, and multi-agency approaches to service provision, greater consumer involvement, and in the context of health and social care, statutory responsibilities to work in partnership (National Audit Office, 2001; Dowling et al, 2004; DoH 1997; 1998; 2000a; 2000b; 2005; 2006). In line with this Northumberland FISHNETS was developed as a multiagency, multi sector, multidisciplinary partnership that focused on the core objective of reducing serious injury in the older population through prevention of falls. Unlike many other partnerships in the field of health that fail to complete their aims and do not survive the first year (Lasker et al, 2001), the FISHNETS partnership has continued to develop and has met the majority of the targets that were established in the POPPs proposal.

Though there are many ways of evaluating the processes that contributed to the functioning of FISHNETS, the Warnwarth partnership conceptual model (Warne and Howarth, 2009) has been adopted as an analytic framework, as it acknowledges the complexity, interrelatedness and messiness of partnership working. All of which are characteristic features of the messy reality of the FISHNETS partnership

that was driven by top-down Department of Health policy and guidance, and a local impetus to acquire new funding to support existing services and develop new ones.

In the Warnwarth framework the notion of the 'good enough partnership' sits at the core of the conceptual model; that is 'is a'partnership good enough to do the job and achieve its aim(s)'. In this model a partnership is conceived of as being influenced by eight interrelated dimensions which are – good reasons for the partnership, high stakes, right people, right leadership, strong balanced relationships, trust and respect, good communication and formalisation. Each of these dimensions were used to interrogate different aspects of the FISHNETS partnership with partners, service providers and service users in order to shed light on the factors that led to FISHNETS developing in the way that it has done. The following discussion does not intend to examine the underpinning assumptions inherent in this model, rather the model is accepted as a given. The discussion does present a synergy of the discussions about each of the dimensions of the Good Enough Partnership.

a. Good reasons for the partnership

When the Department of Health, Partnerships for Older People (POPPs) programme was announced, this provided the impetus for older people, agencies and organisations across statutory, voluntary and independent sectors in Northumberland to develop a partnership This was a unique opportunity for older people, managers and service staff to work in a collaborative partnership to realize a

shared vision of service provision for the older population of Northumberland. This included delivering services that all of the stakeholders considered older people needed across all of the County, in contrast to the inequality of service provision that had existed in Northumberland, and getting the resources and services to older people to enhance their quality of life in later life.

Whilst the reason that the partnership developed was driven by the external condition of entering into competitive bidding for new revenue for service provision, this was underpinned by positive reasons for the partnership, namely, a shared vision, agenda and objectives. When the partnership was successful in securing funding for the project, the external drivers that had established the impetus for the partnership were replaced by an internal imperative to work collaboratively to meet the requirements and the conditions of the grant.

b. High stakes

The stakes are high within the Fishnets partnership in varying contexts.

For the Care Trust and Local Authority success in achieving the aims and objectives of this project have had local and national implications. The reputation of these organisations with key government departments and inspection bodies could have been negatively affected by failure to achieve service targets or perceived lack of commitment to a new and developing policy agenda.

Indeed, a case was made in the bidding process for POPPs funding to support the development of a countywide falls pathway, which had the potential to draw attention to Northumberland's health and social organisations failure to meet National Service Framework targets. There could have been far ranging ramifications of the decision to 'go public' with this information for the statutory organisations involved with FISHNETS. There were also potentially damaging consequences for those with managerial responsibilities for the relevant adult services. Some key players put their professional reputations and future prospects on the line, by championing this project within their own organisation. In one case, for example, FISHNETS was viewed as a distraction from core business, and the individual had to work hard to justify the time and resources that were devoted to FISHNETS.

During the operationalisation period the financial arrangements of the POPPs programme involved financial risks for all partners and required discussions about how the sharing of these risks could be managed within the larger partnership arrangement for the Care Trust, under which the NHS organisation was responsible for large sums of Council funding, using Section 31 of the Health Act, 1999.

There were also potentially important positive outcomes for health and social care organisations that were involved with FISHNETS, none-the-less being the project providing a vehicle for the delivery of unachieved milestones and targets in important older people's policy areas including The National Service Framework for Older People (DoH 2001). As the project has developed these organisations have been able to point to FISHNETS as an exemplar of innovative service development in the

Comprehensive Performance Assessment (CPA). The outcome being that FISHNETS has been instrumental in supporting the organisations star ratings.

For voluntary organisations and independent service providers involvement in FISHNETS carried risks of a different kind. Future contracts and work awarded by commissioning arms of the statutory partners may have been influenced by their performance in this high profile project. Equally becoming a FISHNETS partner had the potential to create new, unplanned opportunities to further their work with the growing older population in Northumberland.

What was unanticipated at the outset of Northumberland FISHNETS was the extent of the profile of the overarching POPPs programme at the highest level of government. This realisation in turn has raised what were initially viewed as high stakes across the whole of the FISHNETS partnership. The ongoing reporting to the national project and evaluation team highlights all areas of activity and this was not initially recognised but has through time become more apparent.

c. Right people

The FISHNETS vision was generated by individuals who came together as a group in their commitment to developing innovative, high quality preventative services for older people. These individuals were sufficiently empowered to make decisions on behalf of the organisation and the older Northumberland County population that they represented within the FISHNETS partnership. This culminated in a successful bid for Department of Health funding. Their success could be attributed to the diverse perspectives, experience and knowledge of the needs of the older

population that they brought to the partnership, and their ability to make timely decisions within this context.

During the initial development of FISHNETS organisational structures were developed to facilitate the translation of the FISHNETS strategy into operational processes and deliverable services. The individuals who had been instrumental in developing FISHNETS maintained their commitment to the project and agreed to take on new roles and responsibilities within this structure. For example, older people community representatives became members of the Older People's Partnership Board who worked in collaboration with service partners to undertake governance and financial accountability for the project. Organisational representatives also agreed to undertake new roles as task group leads or task group members to make operational decisions and oversee the day-to-day implementation of the project. This was a complex undertaking in a situation where services were being delivered across service and sector boundaries and by staff who did not have a history of working together. There was a great need for staff development to enhance their capacity to fulfil new responsibilities. For example, older people board members completed 'Stronger Voice'. training to develop skills and knowledge for their expanding role within FISHNETS.

Implementation of the project also required the recruitment of staff to new posts within the project. This was somewhat problematic in a climate where there was a freeze on new appointments within the host organisation. At times this led to slippage in meeting predetermined targets and frustration within existing staffing as individuals struggled to meet the demands of ever increasing

workloads. The implementation of the project also highlighted the limited commitment of some stakeholders, namely GP's across the County, which had the potential to limit the impact of the project.

Significant changes have occurred throughout the FISHNETS experience with regard to the people involved with this initiative. Toward the beginning of the second year of the project the host organisation, Northumberland Care Trust and key external partner organisations such as Northumberland County council, went through a process of structural reorganisation. These reorganisations resulted in changes to the people within the partnership, when key individuals were made redundant or realigned in their organisations with new responsibilities. This had a considerable influence on the leadership and management within FISHNETS. Whilst this was a time of considerable uncertainty for those who remained and worked to maintain the service and make short and long term decisions, these changes also created the opportunity for new people to join the partnership. It is only now that new relationships are being developed within the FISHNETS partnership and it is becoming clear who are the right people with a reasonable degree of autonomy within the new organisational structures who should be integrated with FISHNETS to optimise partnership effectiveness.

d. Right leadership

Leadership operates at several different levels within FISHNETS. At the National level, the project is one of 19 first wave pilots in the Department of Health POPPs programme. It was clear from the initial prospectus inviting applications that the DoH was looking for local innovation which it could support rather than intending to lead the process itself. As the projects got underway there was increased performance management from the centre with a particular emphasis on economic parameters of service development. This has sometimes been at odds with the local philosophies of partnership and older people centred care, where quality of life and service development are key priorities.

At the local level, strong leadership has been apparent in the FISHNETS partnership. OPPB has a high profile and strong decision making power. Information is fed up to the Board and decisions are cascaded back to the task groups through the project manager, who is held in high regard and her commitment is referred to in a very positive light. Effective strategies, such as devolved task group decision making have empowered individuals to take things forward. People involved in FISHNETS have a high degree of ownership of the project and tend to share its aspirations. Effective communication channels have been used to 'join up' the thinking across and between task groups and the strong role and presence of OPPB has co-ordinated activities and provided a point of reference for all task group activity.

As in any leadership position, the personal qualities of the individual leader are pivotal. The project manager's personal strengths and effective communication skills, therefore, have been crucial in forming effective relationships, trouble shooting across the project task groups and generally facilitating the process of making things happen. FISHNETS has clear aspirations and the shared vision evident in the initiative could not have been achieved without the 'right leadership'. As the FISHNETS project funding now comes to an end, the continuation of effective leadership is more important than ever to secure the sustainability of the partnerships and the service developments that have been achieved.

e. Strong balanced relationships

The partnership was forged in a collective effort that was focused on securing the funding for the project. Everyone worked to this common objective with less attention being devoted to 'getting to know each other.' A consequence of this was the development of linkages between agencies and organisations that enabled commitment to the FISHNETS vision. These linkages did not always translate into interdependent operational processes when the project moved into the implementation phases. In some sections of the project, such as development of handyperson services across the County, independent working practices within the home improvement task group facilitated service development and meeting service targets in a timely manner. In other sections of the project organisational cultures that existed prior to the partnership overshadowed relationships during the initial developments. This resulted

in suspicion between partners concerning organisational agendas, and misunderstandings of the imperatives underpinning the FISHNETS project. Working within task groups enabled the project team to nurture their relationships and during the first year of implementation differences in organisational culture and decision making processes were identified and worked through, resulting in a valuing of the different contributions that partners brought to the project and the development of new ways of working.

From the commencement of the project, attention was given to reducing the power differential between the older people board members and professionals. Board members, for example, received an honorarium for their commitment to the management and governance of FISHNETS. Whilst the payment was an attempt to introduce equality into the relationship, in no way did it represent the many hours of work that board members devoted to the project. An effort to establish equality in this relationship was also evident in the way that Board members were able to influence decisions about appointment of the project team and in service planning.

With the reorganisation of the Care Trust came changes in relationships between the partners. For example, older people members of the Partnership Board had been central to decisions about staff appointments and they had considerable autonomy in decisions about the FISHNETS budget. The reorganisation, which coincided with acute pressures on the Care Trust's budget, resulted in some key decisions about staffing and resources being taken by service managers as part of the wider agendas and this left the Board

feeling marginalised. Reflection on this situation stimulated the Board to develop strategies to forge new relationships with the external host organisation, the Care Trust, to move the project into a new operational context where Local Area Agreements and Local Delivery Plans were significant to its future. The relationship changes that have taken place with the FISHNETS initiative highlight the temporal nature of partnership interactions and the need to continually reflect on and manage relationships that are critical to the effective working of the partnership.

f. Trust and respect

People with diverse backgrounds have been brought together in FISHNETS and professionals from health, social care and the third sector have come together in a partnership with older people and service users. Trust and respect has been evident from the early bid development meetings through to the operation of OPPB.

Respect for each other's points of view has been crucial to the success of the visioning of FISHNETS service developments and the Board does not shy away from the 'big issues'. Strong values are evident in action as challenges are encountered and dealt with. Opinions are openly exchanged and, even where compromise is required, there is a transparent process leading up to final decision making. Most players behave with integrity, have faith in consensus decision making and trust each other's judgements and we have observed and participated in a culture where mutual respect is apparent. Learning and development are high priorities and people are moving forward together in a collaborative manner. The respect, trust and confidence between stakeholders has

been a project success but will be tested in the outgoing phase of FISHNETS where sustainability will depend on maintaining a shared vision for the future. Whatever FISHNETS becomes beyond the project funding, the core values and beliefs that it has fostered will be critical to future success.

g. Good communication

The organisational structure within FISHNETS provides formal links between older people, service managers and service personnel; partner agencies and organisations; and the commissioner and provider of services. This structure provides the foundation for communication processes that enable the partners to openly share information that is required to make the relationship work, including their objectives and goals, knowledge of statutory and non-statutory services for older people in Northumberland County, service data, potential areas of conflicts and changing situations.

Individual members of the partnership exchange their ideas and communicate their concerns with other members through formal structures (OPPB, task group meetings, and supervision sessions) and informal conversations. Face-to-face informal conversations are particularly valued by members as a way of sharing ideas and developing creative ways to 'think outside the box' in order to move the FISHNETS agenda forward.

Developing open and effective communication structures and processes has not always been straightforward. For example, some partners rely heavily on e-mail communication as a quick and accurate method of communication, whereas other partners do not have

access to or do not regularly use e-mail. Hence, methods of communication that were acceptable to everyone in the partnership had to be developed. Though this challenged the partnership, the development of a culture where partners felt genuinely safe and confident to express their ideas and concerns has been more difficult to sustain. A change in the membership of the partnership disrupted relationships, toward the final phase of the project, and has had an impact on communication flow.

h. Formalisation

From the inception of the FISHNETS proposal OPPB provided a strategic structure for organisation representatives to maintain regular communication with each other and it provided a vehicle for decision making during the implementation phase of the project. Importantly the organisational representation on the Board (e.g. Director of Social Care and County Wide Services, Head of Provider services – Older People Services) ensured that decision making processes could result in timely and effective decisions to enable the project team to meet the demanding service deliverable targets that were predetermined in the FISHNETS project proposal that was contracted by the Department of Health.

From the commencement of the implementation phase of the project OPPB linked with middle and operational managers through 6 FISHNETS task groups. In the main the leaders of these task groups held key roles within their respective organisations; therefore they were able to translate the FISHNETS strategy into operational processes and deliverable services.

This provided a structure for strong vertical linkages within the FISHNETS organisation and between the partnership organisations.

With the reorganisation of the Northumberland Care Trust, during the second year of implementation, came a new structure in the FISHNETS host organisation. This resulted in the development of new posts and new people fulfilling the posts. This had a major impact on FISHNETS because some of the individuals who had championed the development and implementation of FISHNETS within the Care trust, including the Director of Social Care and the Head of Older People's Services were no longer with the organisation. There were also changes in the staffing of FISHNETS (e.g. the project lead was appointed to a senior manager position in the Care Trust), which resulted in the need to appoint new staff to the project.

The combined effect of these changes has been partners working in relationships that fall somewhere along a continuum that is characterized by 'permanence' and 'transition'. At its best periods of 'permanence' in relationships in the partnership has facilitated shared decision making that recognised the authority, accountability and responsibilities of individual partner members. Whereas phases of 'transition' disrupted decision making processes and made it harder to sustain mutual understanding that was so important to partnership arrangements. In recognition of the potential detrimental impact of 'transition' phases, the FISHNETS project team sought ways to continuously review relationships and decision making processes, and actively worked to grasp opportunities (e.g. new people, new ideas, new possibilities for funding)

that arise during periods to change to realise the FISHNETS vision for the County.The difference the Northumberland FISHNETS partnership has made to Northumberland community

Partnership working was not an option for Northumberland FISHNETS, it was an eligibility requirement in the application process for POPPs funding. The successful application for project funding provided a banner around which all the FISHNETS partners were able to rally and was undoubtedly a catalyst in developing the partnership that now exists. The preceding discussion has explored the processes and the complexities that have been inherent in establishing and sustaining the partnership. This has not been without its challenges in the wake of the restructuring of partner organisations. Yet the partnership has been sustained with plans for mainstreaming elements of FISHNETS to continue to develop the vision for preventative old age services beyond the completion of the pilot service in Northumberland.

The discussion now moves onto exploring whether the 'partnership has been good enough to do the job and achieve its aim'. In its most simplistic form the outcomes of the FISHNETS project could be measured in terms of performance targets. These were explicit from the outset of the project and have been regularly monitored by the national project team. Service statistics indicate that the FISHNETS partnership has met the majority of the targets and milestones that were established in the POPPs proposal (see page 11 - 14 for further details of service outcomes). On the basis of this it could be concluded that FISHNETS has been successful in delivering service outcomes and in some aspects of the project service deliverables have exceeded

expectation. Such monitoring is consistent with the lead given by the National Audit Office (2001) for the monitoring of performance targets to assess whether partnership initiatives have achieved their intended benefit. However, this evidence does not encompass all aspects of what the FISHNETS partnership has achieved. There is little doubt that many, if not all of the services developed under the auspices of FISHNETS would have developed to some degree without the partnership. Service planning was grounded in the knowledge of evidence and best practice for falls prevention therefore separate services would have individually moved in the direction that has been achieved under the auspices of FISHNETS. What this does not capture is the way that the partnership influenced not necessarily what was developed but how the services were developed and their outcomes.

Permanent Secretary Sir Richard Mottram stated that the ultimate test to be applied with particular rigour, is what works: 'Those keen like me for partnership working of various kinds and for more freedom of manoeuvre for those on the ground must show that it delivers more than the alternative' (Newman, 2001. p.11). This reflects the emphasis in public policy on outcomes and importantly points to the importance of understanding how context and mechanisms interact to produce outcomes (Dowling et al, 2004). The following discussion addresses this point by examining the outcomes that were achieved as a consequence of the partnership and not merely those that could have been achieved by the various partners working alone.

The difference the Northumberland FISHNETS partnership has made to Northumberland community

Working in partnership with older people

Through the FISHNETS partnership older people have been brought to the heart of old age preventative service planning and decision making in Northumberland. Such involvement has been encouraged in the UK by the government through recent policy developments (for example, DoH 1989, 1997, 1998, 1998b, 2000, 2001b, 2003 2004, 2006, Blair, 1996; Audit Commission, 2004). Indeed, OPPB provided a vehicle for the Care Trust to meet the requirements of Section 242, National Health Service Act 2006 in the Care Trust. This Act placed a duty on health care organisations to make arrangements to involve and consult patients, carers and the public in:

• Planning: Not just when major change is proposed, but in ongoing planning of services

• Proposal for development / change: Not just in considering proposals but in developing them

• Decision making: In any decision that may affect the operation of services.

Prior to this Act coming into being the Care Trust were compliant with these statutory duties with respect to its POPPs submission, FISHNETS, in 2005. Older people were partners from the origin of the FISHNETS idea and have continued to work in partnership with organisations in statutory, for-profit and not-for-profit sectors.

It could therefore be argued that the

Care Trust did not merely react to legislative and policy developments, it was visionary in aspiring to bring older people to the centre of decision-making structures within FISHNETS. These were devised at a time when older people generally faced exclusion from service planning and policy development, as reported by the Social Care Institute for Excellence (SCIE):

'Older people are excluded simply because they were old and it was assumed that they could not perform certain tasks and activities' (SCIE, 2004, p. 5).

Social exclusion has been a widely recognized aspect of life for many older people, yet the Care Trust implemented a strategy to overcome the social and economic mechanisms that constrained the involvement of this population in order to change the social conditions of later life in Northumberland. Older people were viewed as part of the citizenry, and by providing supportive approaches that enabled them to participate in decision making processes, they developed the capacity to get involved much more effectively than previously thought possible. This strategy upheld the legitimate right of older citizens to have a say in decisions that affected them and provided opportunities for older people to exercise their moral duty to take part in the construction and maintenance of their community.

The FISHNETS governance arrangement that is executed through OPPB ensures the fullest range of involvement of older people in decision-making. This includes commenting on plans, consultation, instigating activities, taking responsibility for carrying out tasks and leading service planning groups. Wilcox's (1994) model of involvement stresses the importance of adopting

different levels and types of participation in different circumstances, and in keeping with this the FISHNETS organisation enabled older people Board members to continue to extend their roles as their skills and expertise developed. The Care Trust supported this by providing ongoing training, such as Stronger Voice training, to enable them to increase their capacity to participate in service planning.

The ongoing development of Board members has been instrumental in maintaining the voice of older people in Northumberland's health and social care organisations. For example, during the reorganisation of the Care Trust in 2007, OPPB sought ways to influence decision-making structures to ensure that there was a vertical linkage between OPPB and decision-making structures within the new organisation. They have achieved success in achieving recognition in the Trust that FISHNETS is more than a project with a time limited beginning and end – it is a pilot to bed the preventative agenda in the Trust and seek maintenance of this agenda into the future. There has been an inevitable tension between this objective and the financial pressures on the Care Trust. Board members recognise that hard decisions must be made within the Trust about service provision; however they are working hard to ensure that this is not at the expense of preventative and rehabilitative services.

As the external, organisational context has continued to evolve and change since the implementation of FISHNETS, OPPB has attempted to influence the older person's agenda in relevant agencies/organisations. Notably, OPPB has sought ways to influence the Northumberland Strategic Partnership (NSP). This partnership was developed in

response to recent policy that led to the creation of Local Strategic Partnerships (LSPs) across the country. These partnerships brought together at a local level the different parts of the public sector as well as the private, business, community and voluntary sectors, so that different initiatives and services support each other and work together. LSP's are responsible for developing and implementing local Community Strategies (variously described as Community Plans, Community Initiatives).

When OPPB members were invited to participate in the NSP Older People's Strategy group (OPSG), the subpartnership representing older people in Northumberland grasped this challenge, recognising the importance of influencing the Community Strategy, Local Area Agreements and Local Delivery Plans through Northumberland LSP. Undoubtedly this created new possibilities to move the older person's agenda forward in Northumberland, however it also brought with it the pressure of fulfilling dual roles: OPPB and OPSG membership. This situation has highlighted limitations in the capacity of older people who are currently involved with service planning and policy development through FISHNETS. Whilst this is somewhat restricted to the members of OPPB and a research group that has developed under the auspices of FISHNETS, increasing the participation of older people was envisaged from the outset of the project. This, however, has not been realised at this stage in the development of FISHNETS.

The future success of involvement of older people in service planning and policy will depend on developing capacity from the wider community.

Structures have been developed to support involvement and there has been a cultural change in Northumberland where there is now a willingness to listen to the voice of older people. Across all service sectors there is a growing recognition that what older people want is achievable and may require a different way of delivering services. Whatever the future, Northumberland FISHNETS has created a legacy of partnership working between older people and service providers that had not previously existed.

Transformation of the service culture from treatment to prevention

The FISHNETS partnership has laid the foundation for an important cultural change in service provision in Northumberland whereby the maintenance of good physical and emotional health in later life is now viewed as important as the treatment of poor health. This is most starkly evidenced in the NSP strategy for the older population of Northumberland (NSP, 2007) that seeks to support older people to remain in the first two phases/stages of later life – older workers and third agers (see p. 7 of this chapter for further details).Traditionally old age health and social care in Northumberland reflected service provision elsewhere in the UK in being illness-focused, service-led and medically-driven. This resulted in an old age service that fostered dependency in later life and one where little attention was given to developing preventative approaches that enable older people to be as healthy and independent for as long as possible.

Many factors came together to prepare the ground for the impact that FISHNETS has had on the

transformation of the service culture in Northumberland. The project was implemented at a time when there was increasing acknowledgement of changes or pending change to the demography of the County.

In some sections of the economy of care this was viewed negatively and was perceived as an impediment to achieving the following targets:

Long Term Conditions PSA target- To reduce emergency bed days by 5% by 2008.

Older people's PSA target - To improve the quality of life and independence of vulnerable older people by supporting them to live in their own homes where possible by;

- increasing the proportion of older people being supported to live in their own home by 1% annually in 2007 and 2008; and

- increasing by 2008 the proportion of those supported to live at home intensively to 34% of the total of those being supported to live at home or in residential care.

Significant change had to occur, to enable services to meet these targets. This added to existing concerns across old age services that Northumberland was falling behind in meeting targets identified in the NSF for older people (Department of Health 2001), namely Standard 6, which specified that older people who have fallen should receive advice and intervention from specialised falls prevention services.

Other policy developments also provided a clear signal to Northumberland services that change was required. The White Paper Modernising Social Services (1998c) gave explicit recognition to the importance of preventive approaches as a response to the needs, problems and concerns of later life. In keeping with this policy direction, in January

2006 the DoH published the White Paper 'Our health our care our say: a new direction for community services.' This Paper set out a ten year plan for how health and social care services would be redesigned to be more convenient and responsive to people's needs in the 21st century. Key to implementation of this plan was development of the evidence base, which was to be derived from learning through a range of pilots and demonstrators in the early stages to ensure that roll out of new services and methods of service provision would work for people and take services into the future. The POPPs programme was one of these pilots.

The POPPs pilot fell under the section of the White Paper relating to Healthy Living, Prevention and Well-being. This emphasised the need for continual improvement in the health and quality of life of people in England. To achieve this there had to be a move from a culture which prioritised treatment of illness to one that considered maintenance of good health as important as the treatment of poor health. To do this, services had to develop to enable people to look after their physical and emotional health and to support individuals in a way that suited their lifestyle. The White Paper set out action to bring about these changes. The POPP pilot was designed to test out radically different ways of providing services to older people.

As a POPP pilot, Northumberland FISHNETS aimed to support independent living of older people in the community and promote healthy and active ageing. A specific objective of FISHNETS being the reduction of falls, and the associated injuries resulting from falls in the older population. Through the combined development of prevention, early intervention and changes to the way

services are now provided across health and social care FISHNETS has brought about services and approaches that:

- support independence and interdependence in later life

- provide integrated, holistic and flexible packages of care and support for the prevention and treatment of falls in the older population

- focus on prevention of ill-health and promotion of well-being to enable older people to live full, healthy and independent lives as they grow older.

Toward the end of the pilot, the FISHNETS project team is focused on maintaining the cultural change that has been achieved and sustaining this into the future. There is now commitment to the preventative agenda in the County through NSP, however pressures such as releasing funds from acute hospital care and reinvesting in prevention are major challenges to the sustainability of the cultural change to promoting prevention and wellbeing in later life that has so far been achieved. There are a number of reasons for optimism that the key benefits of FISHNETS can be sustained. The Care Trust is now in financial balance, and the creation of a unitary council for Northumberland will bring together in one organisation lead responsibility for a wider range of public services for older people, including the planning of older people's housing, grants for adaptations, and some key preventative services such as leisure services and community alarm services.

A whole-system response to prevention

Older people, particularly those of an advanced old age potentially require support from a number of agencies across a number of services, including primary/secondary health and social care, housing, transport, leisure, and education in statutory and independent sectors to promote well being and prevent the health, social and personal challenges of later life. However, evidence continues to suggest that the current organisation of services do not achieve integration of service provision. Despite policy directives for joined-up services and whole-system working, and various reorganizations to implement these directives, gaps in and between systems of service provision cause a variety of problems for older people, providers and commissioners. The problems, such as fragmented and discontinuous experiences, have been well documented and have been attributed to the following factors:

- demarcation of professional responsibilities and the 'turf wars' that exists in the boundaries between services and professionals

- reneging and shunting of responsibilities across the boundary of health, social care, housing and leisure

- weak channels of communication between and within organisations

- a lack of free flowing information across the whole service system

- that there are multiple points where older people access services with no centralised systems to co-ordinate what/when older people access services

- older people are routinely, systematically assessed and reassessed by multiple agencies and different professionals with minimal

(RCP/RCN/BGS, 2000; McCormack et al 2004; Reed et al 2005, 2007)

Whilst these problems are well recognised there have been few services implemented across the whole system of old age service provision. In contrast Northumberland FISHNETS was ambitious in its plans for a whole-system approach to falls prevention. This required wide spread change in FISHNETS partner organisations, and involved developing understanding of their contribution and that of other partners to impact on falls prevention; what services they had to offer to falls prevention; competence of the workforce to undertake preventative work or be skilled-up to carry out this activity; the historical and spatial influences that enabled or inhibited partners working together, patterns of power, authority and hierarchy needed to be understood; resources, information availability and feedback processes that could be utilized to operationalize the FISHNETS vision. All of these factors shaped and have continued to reshape FISHNETS as the initiative has developed.

Partners are clear that the whole-system approach that has been adopted by FISHNETS has not been easy. The difficulties highlighted in the bullet points above have challenged everyone who has been involved in the project. Yet partners believe that one of the key outcomes from the whole-system approach to the development of FISHNETS services has been services that are comprehensive, joined-up across the economy of provision and focused on the needs and concerns of older people. This is illustrated with reference to the Falls Pathway that now exists in the County. A Falls Pathway is a schematic diagram of the services that are available to people in a particular locality, who are at risk of falling and those who experience falls (see Fig. 2). The schematic representation portrays how services link with each other, and provide a visual illustration of services that users can access following assessment and referral.
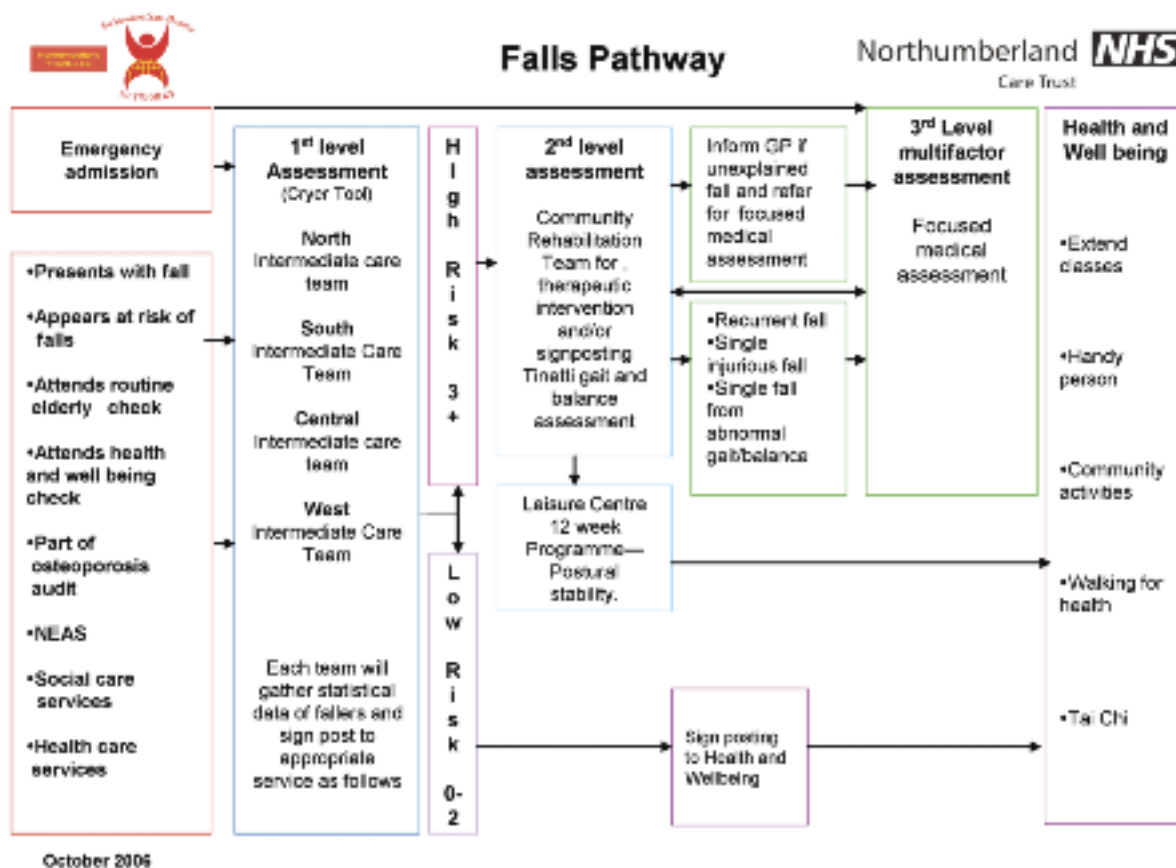

Figure 2: FISHNETS falls pathway

In Northumberland the FISHNETS intermediate task group led the development of the Falls Pathway (see figure 2). This involved consultation with services and professional groups across the whole system, and importantly the team negotiated with relevant services to secure their commitment to the operationalisation of the Pathway. A unique feature of the Pathway is that leisure, housing, transport, health and social care services are represented. This ensures that the Pathway is comprehensive and includes services across the continuum from community-based health and well-being interventions to intensive hospital-based interventions. Hence, preventative as well as treatment interventions are now available to older people. This has necessitated the development of new services such as the 12 week leisure-centre based falls prevention exercise classes, as well as linking existing services together, such as Community Rehabilitation services and handyman services to make homes safer places for people to live.

In addition to the services that are represented in the Pathway being identified through the consultation process, they have been grounded in knowledge of contemporary falls prevention evidence. For example the emphasis on exercise and physical activity in the Falls Pathway is in response to the NICE guideline and builds on the work of Skelton et al (2005) who demonstrated that a balance and strength retraining group combined with a home exercise programme reduced falls in a group of high risk community dwelling older women. A randomised controlled trial by Barnett et al (2003) tested an intervention programme designed to improve balance, coordination, aerobic capacity, function and muscle strength coupled with educational

information regarding strategies for falls prevention. A control group received only the educational information. The intervention group performed better in some of the balance measures and fell 40% less than the control group during the 12-month trial period. Day et al (2002) investigated the individual and combined effects of three interventions; home hazard management, vision assessment and group exercise on balance, strength and frequency of falls in people aged 70 years and over. The strongest effect was found in the groups receiving a combination of the interventions, but when analysed in isolation, the group exercise programme demonstrated the greatest improvement in outcome.

There is little doubt that the whole-system service developments, such as those represented by the Falls Pathway, which now exist in Northumberland provide more opportunities than ever before for older people to live full, healthy and independent lives as they grow older. These developments are fragile, and are dependant on the on-going commitment of service partners. Lack of funding to support some aspects of the preventative services has the potential to damage the whole-system service structure that has been created through FISHNETS and with this there is always the potential that services will revert from the wide ranging continuum of services to a restricted focus on treating ill-health.

Key messages

Northumberland FISHNETS has been the 'good enough partnership' to respond to the opportunities that were made available for development of old age preventative services through the POPP initiative. It has achieved its aims, as evidenced by target-based criteria. A comprehensive falls prevention programme is now available across Northumberland County including campaigns to raise public awareness of the benefits of exercise and falls prevention, community rehabilitation team intervention, falls prevention exercise programmes in leisure centres, community based exercise and interest programmes, and home improvement through handyman and telecare services.

There is general agreement across service commissioners, service providers and older people that they wish to see FISHNETS continue and expand into the future. Whether the partnership is 'good enough' to realize this ambition remains to be seen. There are many challenges for the partnership including uncertainties about medium and long term funding, incompatible priorities, loss of continuity due to changes in key personnel who championed the preventative agenda in the Care Trust, changing health and social care policy, which together add uncertainty to the future. Whatever the future Northumberland FISHNETS has created a legacy of partnership working between older people and service providers, and the knowledge that preventative approaches to the particular circumstances of old and advanced old age have the potential to improve quality of life.

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Appendix

Appendix 1: Key Northumberland documents

Northumberland Sustainable Community Strategy – Northumberland Strategic Partnership, May 2007 (available at www.northumberlandtogether.org.uk)

Working Together (Northumberland Local Area Agreement), refreshed February 2007 (available at www.northumberlandtogether.org.uk

A Sub-regional Housing Strategy for Northumberland, 2007-2011, Northumberland Housing Board, July 2007 (www.tynedale.gov.uk/residents/showdesc.asp?id=210)

Learning for Life – the 2020 Vision for Learning in Northumberland, Northumberland Strategic Partnership and Northumberland FACT, September 2007 (www.nsp.org.uk/downloaddoc.asp?id=1149)

Northumberland Local Transport Plan 2006-2011, Northumberland County Council 2006 (http://pscm.northumberland.gov.uk/pid/90016.htm)

Northumberland Community transport strategy, Northumberland County Council 2008. (www.northumberland.gov.uk)

Community Safety Policy, Strategy and Procedures Manual, Northumberland Fire and Rescue Service, 2006

Healthy lives, stronger communities, a strategy to improve health and well-being in Northumberland, 2007 (available at www.nsp.org.uk)

Northumberland Area Tourism Management Plan, 2006-2009 (available at www.nsp.org.uk)

Northumberland Carers Strategy (reviewed 2005, for review 2008 for 2008-2011) (available at www.northumberland.gov.uk/carers)

Appendix 2: Regional documents

Better Health, Fairer Health, A strategy for 21st century health and well-being in the North East of England, 2008 (available at www.gone.gov.uk/gone/public_health/)

The Region for all Ages: a vision for ageing and demographic change in North East England – Years Ahead, The North East Regional Forum on Ageing, 2008 (available at www.yearsahead.org.uk/)

Appendix 3: National policy documents

The overarching national strategy for older people is Opportunity Age, the first report on which was published in 2005 and is available at www.dwp.gov.uk/opportunity_age/

The 2006 report A Sure Start to Later Life, published by the Social Exclusion Unit, focuses specifically on older people who are at risk of social exclusion. It is available at www.tinyurl.com/37hurh

The Government's rural strategy, published in 2004, discusses issues arising because of the ageing of the rural population. It is available at www.defra.gov.uk/rural/strategy/

Key policy and guidance for older people has been published in documents such as the

- The National Service Framework for Older People published by the Department of Health in 2001.

- The White Paper on community health and social care services: Our Health, Our Care, Our Say 2006.

- `Everybody's Business (2005), about older people's mental health services.

These and many other Department of Health publications about health and social care for older people are available on the web at www.tinyurl.com/2yjn57.

National policy on housing for older people is set out in the February 2008 strategy Lifetime Homes, Lifetime Neighbourhoods (www.communities.gov.uk/housing/housingmanagementcare/housingolder/)

Notes

Chapter 3: Urban Regeneration: Making a Difference? A Case study of a New Deal Partnership in action

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Contents

Executive Summary

1. Under the auspices of 'Urban Regeneration: Making a Difference', this case study was part of a project to investigate the factors which impact on partnerships being able to work together to change the health and well-being of local communities.

2. The research had two aims:

2.1. To be of tangible benefit to the participants, and stimulating to their partnership development

2.2. To contribute towards developing an evaluation package for partnerships (based upon a framework devised by 2 members of the project) which could subsequently be used on a much wider scale

3. Nine semi-structured interviews were conducted which were fully transcribed and analysed using NVivo 7 software.

4. The case study chosen was the Health and Social Care Steering Group for Impact*, a New Deal for Communities Programme. As such it was a partnership without formal structures where the affiliations between members were quite 'loose'.

5. Because the partnership was in the process of changing from a highly funded New Deal for Communities (NDC) programme to a social enterprise the research was timely and of practical use in shaping its future role

6. Aspects of partnership working were encountered which rarely feature in the literature but which are to do with informality, continuity and a commitment to improving people's lives through sharing and collaboration. This is an arena some distance from the formal, structured and conventional partnerships upon which policy is founded but which represents the day-to-day experiences and reality for those working under the regeneration field.

7. Recommendations were that:

7.1. The role and function of the group needed to be clearer, with terms of reference known to all.

7.2. Group membership should be reviewed to reflect its role and function and should include social services and local government staff as well as community representatives.

7.3. How the group links in – or could link in – with other partnerships needs to be established to ensure it meets a need not provided by other organisations.

7.4. The strong leadership of the group should be maintained and consideration given to succession planning for if, or when, the current leader is no longer in this role.

8. Presentation of these outcomes at a workshop with the participants stimulated future planning and helped the group consider reconstituting itself to:

8.1. Act as an umbrella organisation for all health and social welfare projects operating in the locality.

8.2. Have responsibility for identifying health and social care needs and advocating these with funding bodies (PCT, local authority).

8.3 Provide advice and help on accessing funding.

8.4. Act as a link with, and voice of, community groups and individuals.

8.5. Reflect the goals and strategy of the Local Area Agreement at the local level, which is currently a very grey area.

9. The researchers will help the group carry this plan forward thereby fulfilling the key aims of the Urban Regeneration programme in forging an alliance between the University and practitioner organisations.

10. The Warnwarth framework proposed 8 key aspects of the 'good enough partnership' which were instrumental in designing the interviews and directing us towards avenues of enquiry which might otherwise not have been considered. This enabled the subtle relationships within the partnership to be revealed and the identification of its strengths and accomplishments.

11. Critical examination of some of the assumptions of the framework, in the light of the research, suggested further aspects to consider:

11.1 The importance of the continuity and history of partnerships.

11.2 Explicitly address 'sustainability'.

11.3. the local context in which partnerships operate.

11.4. the significance of partners' relationships outside the partnership.

11.5. the complex aspects of the role of leader and the use of power.

11.6. the 'networking' feature in partnerships.

11.7. informality.

11.8. acknowledging more explicitly the interdependence of some of the framework aspects

11.9. the potential to engage with Newman's work on the dynamics of partnership.

Introduction

The Urban Regeneration programme has two aims (see The Project Context):

- To address key urban regeneration challenges in the North of England through interdisciplinary collaboration between the partner universities and practitioner organisations, particularly in the public and voluntary sectors, and to enhance their collective impact on society

- To build a long term strategic alliance between core university partners while developing a distinctive form of knowledge transfer, which is both teaching and research driven, in order to meet the needs of organisations and professionals in business and the community.

The Role of Partnerships project was set within the 'health' theme of the programme and draws on data from 5 case studies of urban partnerships to determine the effectiveness of working practices and the learning needs required to sustain them.

For the purposes of this research, the specific research question was:

What factors impact on partnerships being able to work together, effectively, in order to change the health and well-being of local communities?

Within this framework were additional questions:

- What catalytic, prescriptive, informative and supportive interventions promote or inhibit partnership working?

- What factors influence change in the health and well-being status of local communities?

- To develop a 'best practice resource kit' for assessing partnership working in the context of the health and wellbeing of urban communities.

The Case Study

This chapter reports on one case study, the Health and Social Care Group, a subgroup of Impact, a New Deal for Communities (NDC) project.[1]

Background

The need for health and social care professionals to work together, collaboratively, has now long been accepted and continues to be regularly emphasised through Government documentation and legislation, for example the NHS Plan (DoH 2000) and the Common Assessment Framework for children (DoH 2003). Despite this, there continue to be many factors that can impact[1] on partnership working taking place effectively:

• Differing agency targets, management practices and

• Accountability

• Time constraints

• Financial constraints

• Professional boundary dilemmas

• Problems in information sharing and maintaining confidentiality.

(Allen, 2006: 161)

A commitment to partnership working however can overcome these barriers given:

• Familiarity with each others' job

• The development of strong personal and professional relationships.

(Sullivan and Skelcher 2002)

How far is this possible and what actually happens in practice? Reflecting the complexity and multidimensional nature of partnerships, our research is also complex and looks at how far, and in what way, the goals of partnership

are delivered 'on the ground' through a loosely structured, but task centred, network under the umbrella of a conventional Government directed, and highly structured, partnership – the New Deal for Communities. Evidence from this research will be analysed using the prototype Warnwarth framework containing 8 ingredients for the 'good enough partnership' (see Appendix 1).

In each case we shall scrutinise data from in-depth interviews with network members to see how far the model both explains the dynamics of the network and identifies features whose presence or absence influences its successful function.

National Context

Impact is one of 39 New Deal for Communities (NDC) partnership projects planned to run over the period 2000 – 2010. Hailed as "one of the most important area based initiatives ever launched" (Neighbourhood Renewal Unit, 2003:i), and with a total budget of £2bn, the 'New Deal for Communities' programme has its origins in a cluster of regeneration Area Based Initiatives including - City Challenge, Estate Action and Single Regeneration Budget. Interventions under the NDC programme have to focus on 6 key outcomes: community development/engagement; improving housing and the physical environment, health, and education; reducing worklessness, and fear and experience of crime. The goal is not only to improve conditions in each area but:

provide an ideal vehicle through which the neighbourhood renewal community as a whole can learn 'what works and why' (ibid)

Hence learning from the NDCs was expected to influence future neighbourhood renewal strategy. In common with the Government's approach to all public service reforms there was to be an emphasis on community participation within the delivery and governance of services (Skidmore et al, 2006), and nearly all NDC partnerships have a majority of elected local representatives on their boards. The extent to which the community as partners influenced and affected outcomes is a criterion against which NDCs must be assessed and hence is an important issue for this research into the effectiveness of partnerships.

Health interventions within NDCs mainly focused on promoting healthy lifestyles; enhancing service provision; developing the health workforce; and working with young people. However, in the evaluation "Health has tended to be viewed by many Partnerships as a relatively low priority, often being viewed as a personal rather than community concern" (CRESR, 2005:191) and, "in the 4 years beginning 2000/01 about £48 million of Programme resources was spent on health, less than for any other outcome area" (ibid: xix) with only minor changes in health indicators. The evaluation identified some clear policy implications:

• The need to work in partnership with Primary Care Trusts (PCTs) to develop strategic, long term plans;

• The importance of NDC Partnerships giving health the emphasis it deserves;

• Accepting that outcomes from interventions will take many years to feed through.

(CRESR, 2005: xix)

1 Impact is not its real name

Local Context

The area in which Impact operates is multi-ethnic and was, in 2000, particularly deprived on the basis of many indicators: "crime was high, educational standards low, community facilities poor and health bad" (extract from Impact website). Its score on the index of multiple deprivation was somewhat lower than the mean of 52 for all the NDC areas and 22 for England as a whole. Impact's Board of Directors has a majority (12 of the 22) of elected community representatives, in common with the other schemes nationally.

Like other programmes, Impact's health interventions were:

To see that the health, environmental and social needs of all residents are met in order to improve their quality of life.

Table one below identifies ways in which Impact is implementing interventions on these criteria.

Because the NDC philosophy was that programmes should be community driven, Impact had the facility to fund packages of interventions best suited to meet the needs of their local areas. Under the 'health umbrella' there were four broader programmes to which intervention projects would be contracted and through which they would be managed. In addition, topic-based steering groups provided advice and support to the projects (see Appendix 2). One of these is the Health and Social Care Group and is the focus of this research.

Although scheduled to run until 2010, funding actually terminated on April 1, 2008 and Impact is in transition from a 'regeneration programme delivery organisation' into a 'social enterprise' where community representation, and hence the experience of partnership working, will be at a different level.

Table 1

- Our projects are aimed at improving the health of babies and young children, equipping residents to improve their diet and lifestyle and equipping residents to improve their mental and emotional well being

- Impact has set up a healthy living network at local facilities, so residents can easily get to the services they need

- We are providing services that take account of the needs of many different groups of people in the area. These include exercise classes, advice on diet, cooking classes, stop smoking clinics, ante-natal advice and improved childcare

- We are working to support parents and families. We are offering advice and counselling aimed at reducing stress and isolation, and drugs counselling and support

- We are creating a cleaner, safer environment for all

The Health and Social Care Group

The health and Social care Group (HSCG) manages around 20 projects, with partner agencies providing expertise through the group by planning joint events, sharing information, managing clients/referrals and setting up a support system. More recently, professional advisers were introduced -- largely from the then four Primary Care Trusts. In this way health projects, or health and social care aspects of other projects, were delivered across the whole of the Impact area.

There is now a shift in Impact makeup and governance towards a social enterprise model, with no central funding, which will have a geographical focus on the three 'parish' areas within Impact; programmes will therefore become much more localised and locally accountable. Community representation, hitherto by having borough council members and elected community representatives on the Impact board, will be replaced by parish council nominees although parish councils currently do not exist. Hence a metamorphosis is under way and the nature of the partnership itself is bound to change. The transition is seen by some members of the health and social care group as a significant challenge and there are fears that increased parochialism will result in an emphasis on tackling 'crime and grime' with the 'improving health' agenda losing out.

Research Design and Practice Methodology

The choice of the HSCG as the research object arose for several reasons. One of the authors was experienced in regeneration initiatives over many years, was familiar with Impact's work and, through personal contact, was confident of access for the research. More importantly, however, it enabled the project to focus on an area of partnership working where the affiliations between members were likely to be quite loose and hence, unlike a formal partnership (the Impact board, for example) active membership required a 'payoff' – there needed to be something in it for the participants and their organisations. We were aware too that members of the group consisted of project managers as well as partner agency representatives and hence the dynamics and power interaction would be instructive. We also wanted to see how far the 'community' imperative, so clearly enshrined both in the terms of reference (and the composition) of the Impact board, manifested itself 'on the ground' and how far the health and social welfare concerns of the area were both identified and addressed through these mechanisms.

Because our participation in the main project has been exclusively focussed on this case study the methodology itself has been fairly closely defined and aimed particularly at assessing the Warnwarth partnership template. This has enabled us to concentrate on the mechanism of partnership processes through in-depth interview of the participants and addressing such fundamental research questions as:

Why is there such a group?

Why are members involved?

What does the partnership do?

When does it function as partnership i.e. what sort of partnership is it?

How effective is it?

Although described as a 'case study' the main empirical sources of data are the interviews themselves analysed in the context of reports arising from the National Evaluation of New Deal for Communities. Additional material came from a workshop conducted with the group as it contemplated its new role as a social enterprise.

The workshop was led by the researchers and drew upon emerging themes in the research at that point.

Alongside theoretically driven questions set out at the beginning of this chapter, the overarching aim of the Urban Regeneration programme is to stimulate collaborative working through active involvement by Higher Education institutions. Hence we see the analysis and development of this process as part of the research because it tests the dynamics of a partnership in a fundamental way by challenging its ability to change and adapt to meet different challenges.

Selection

While the 'cast' of interviewee participants consisted primarily of those involved in the group, we were aware of changes that had taken place over the years, by the nature of projects coming and going and hence identified three broad 'categories' of membership:

1. Those who have left the partnership since 2001

2. Those who are still engaged but have experienced the transition and are giving thought to their own future role

3. Those who will shape future development

This basic categorisation had implications for the questions we would explore with them.

In group 1 we asked why they were members of the partnership in the first place; what it meant for them and their agency's ability to achieve its own goals; perspectives on the process and where the power lay; what sustained the partnership; why they withdrew etc.

In group 2 we were aware that not only would some of the above issues arise, but also their perceptions of the changing dynamics of the partnership.

For group 3 we looked in particular at how the health theme could be sustained in the face of the likely parochial emphasis on quick and visible outcomes.

The selection of participants for this study, therefore, was purposive.

Research Practice

Research participants were invited to take part in the interviews on the basis of the above criteria and drawing on the current membership of the HSCG. The initial contact was by letter followed up by telephone discussion by one or other of the researchers when interview arrangements were made. Formal consent forms were used and all interviews were tape-recorded. The interview schedule was designed both to reflect the Warnwarth framework criteria and to facilitate open discussion.

Analysis and Findings

Analysis of the data took place through two inter-related processes as follows:

o **Analysis of the interviews.** All interviews were transcribed and analysed using NVivo software. Template analysis was used in order to establish preliminary themes based on the original questions from the semi-structured interview schedule with additional tree and free nodes created as new themes emerged from the data

o **Evaluation of workshop.** Results were fed-back to the original research participants and members of the Health and Social Care group in a workshop environment. The workshop was led by the researchers and participants encouraged to consider the results of the study in relation to their group and its effectiveness as a working partnership. Evaluation of the workshop was then undertaken in order to re-evaluate the analysis in relation to the interviews alone

Although interviewees were selected on the basis of their length of time in the group we were unable to discern any relationship between this categorisation and the views expressed.

Workshop

We give this 'special mention' here because of its unusual place in conventional research. In fulfilling the goal of stimulating collaborative working, and being seen to be useful to the participants, the research outcomes presented at the workshop were those which we saw as being of practical use and drawing upon the experiences of the group. The presentation made by us to stimulate discussion and planning contained a mixture of interview quotations, relevant extracts from research and our own interpretations.

The presentation was under four broad themes that had emerged from the data as follows:

• What has been the role and function of the group?

• How has this been affected by its composition?

• How do you ensure sustainability?

• What are the internal and external factors than can influence this?

What has been the role and function of the group?

It was clear from analysis of the interviews that the role and function of the group had different meanings to different people. For some it provided a network which gave them access to other health and social care professions and for others it was an opportunity to share information regarding projects which were managed and funded by Impact and in which participants were involved. For others the role and function lacked clarity and appeared to have different goals although one broad remit was identified: to promote health and wellbeing in the local community.

How has this been affected by its composition?

A key impact on the group's composition was that it appeared to have two functions: one being to present feedback on projects funded by Impact and the other to act as an information sharing point:

"The [health and social care] group itself is quite disparate, lots of different people involved in different projects (...) with some people over a short period and some having quite a long period in it" (INT ii)

The impact of the former function was that membership was not consistent. Group membership comprised people who were project leads and key people from the local Primary Care Trust, who were not. Some of the projects, however, were only short term (for example 12 months) in duration and resulted in a quick turnover of some members of staff and therefore a lack of continuity in group membership. Others (such as some of the PCT staff) were not involved in the actual project management and therefore found their own role on the group to be unclear, resulting in a drop in their attendance over time.

"Yes over a period of time attendance got less and less and less err and I think that is because of how well err it achieved its function people weren't getting what they wanted so..."(INT vi)

Wilson (2005) has argued that for effective interprofessional partnerships to work there needs to be a strong sense of personal identity of individuals making up that partnership. We did find, however, that the rationale for group membership was not always clear and could, therefore, be a

reason for the drop in attendance. Equally, we felt that there were key organisations that should be represented but were not. There was, for example, no one identified from social services on the group, nor from the local authority.

In addition, whilst the remit of the group was identified as being to improve the health and wellbeing of the local community, there were no community representatives on the group apart from one Impact Board member.

"There are many within the community and in small groups which could become part of the social enterprise and who we need to reach. And we know who they are and that they are hungry for this sort of thing" (INT x)

How do you ensure sustainability?

The withdrawal of Government funding for Impact clearly affects the way in which the group will continue to function. The changing role of the PCT, from provider to a primary commissioner of health funding in the area, for example, was also identified as having an impact on this. To ensure that the group continued to have a role and function, it was recognised that they would need to both develop a way of working more closely with the local community members (despite the challenges that this causes) as well as with other local service providers. We also suggested that the group would need to find a 'niche' and offer a service not currently provided by others in the local area. This was re-iterated by a comment from one of the interviewees who said:

"They do need to make sure that they've, they've got the mix right and they're not, not duplicating really" (INT iv)

What are the internal and external factors than can influence this?

One key factor considered to be a positive influence on the group was the strong leadership from someone who was committed to maintaining relationships with group members even if they failed to attend the meetings;

"['we've had] very strong leadership. They kept the relationship up they kept managing the relationship even though we don't get to meetings… [the leader] just keeps hanging in there you know she'll call you and send emails and you know arrange to meet you just to sort of up-date you" (INT iv)

The downside to this, however, is that the group has long relied on the one person whose loss could be very disruptive to the group's activities. Indeed, Robson & Cottrell (2005) emphasise continuity of membership as key to effective interprofessional team working. If the current leader were to leave, therefore, this could have a negative impact on the functionality of the group not only by losing the skills of the leader him/herself, but also in terms of the formation of the group.

Whilst the current strong leadership was seen as a positive influence, other factors were considered to have had a more negative impact. One such example given was the changing role of Impact and the feeling that the group had been in a transition phase for a long period but with no clear direction as to what it would end up becoming.

This was felt to be particularly challenging when recognising that other organisations or 'partnerships' with whom they worked were also changing so there was never a static role for any organisation.

Additionally, whilst it was identified as important to engage local community members, the difficulty of doing so was recognised as this was continually changing too.

"We've had local people involved in it and provided that these people don't actually ... because what's happened previously is that local people have lived there and as soon as their financial circumstances have improved they have left" (INT ii)

In summary, the key issues were identified as follows:

- The role and function of the group needed to be clearer, with terms of reference known to all

- Group membership should be reviewed to reflect its role and function and should include social services and local government staff as well as community representatives

- How the group links in – or could link in – with other partnerships needs to be established to ensure it meets a need not provided by other organisations

- That the strong leadership of the group be maintained and consideration given to succession planning be considered for if, or when, the current leader is no longer in this role

Developing a New Group Focus

Having provided the group with the feedback, the remainder of the workshop involved the group considering how, or if, they wanted to address the issues identified.

The key issues were again discussed by the group and its role and function re-considered. It was felt that the overriding goal of the group: to improve the health and wellbeing of the local community, was appropriate and should be maintained. It was interesting to note the high level of motivation from within the group and its commitment to seeing it continue. Members present did feel that the group could have multiple roles and, following debate, felt that it should be expanded to include a wider circle of people. This included local General Practitioners (GPs), community members, social and midwifery services. Consideration was given as to whether there should be two groups: one operational and one strategic in place but this proposal was dismissed as there was a strong desire to retain the relationships built up over the years and the members saw benefit in continuing to combine these functions.

Several members of the group wanted a more pro-active role in improving local health and well-being than had hitherto been evident and decided to look at the possibility of establishing an Impact Health and Wellbeing Partnership (working title) which would

- Act as an umbrella organisation for all health and social welfare projects operating in the locality

- Have responsibility for identifying health and social care needs and advocating these with funding bodies (PCT, local authority [LA])

- Provide advice and help on accessing funding

- Act as a link with, and voice of, community groups and individuals (one of our suggestions in the presentation)

- Reflecting the goals and strategy of the LA at the local level, which is currently a very grey area

We will host and facilitate a meeting in early July to which key strategic people from the PCT and LA have been invited

Outcomes and Evaluation of the Warnwarth Framework

As we indicated at the beginning of this chapter the Impact case study is part of the Role of Partnerships project which draws on data from 5 case studies of urban partnerships to determine the effectiveness of working practices and the learning needs required to sustain them. We have already looked at how the research has identified issues which are important for Impact as it moves into its new phase but we also need to see how far the data from this case study can contribute towards an evaluation model for wider application, a primary focus of the overall project.

As a preliminary to the case studies, two members of the project (Tony Warne and Michelle Howarth) undertook a comprehensive review of the 'partnership' literature and developed the Warnwarth framework, a "conceptual partnership framework that can be used to undertake case study evaluations on a range of different

current health and well-being regeneration projects" (Warne and Howarth, 2009:2). The framework was used to develop the interview schedule used in the Impact research and we now consider to what extent it was of value in identifying how far the partnership was 'good enough'. The concept of the 'good enough' partnership invites the evaluator to consider a partnership not just in terms of how far it fulfils certain criteria but in the context of what it is for and whether it is adequate for the task.

The 'good enough' partnership (Warne and Howarth, 2009:46) owes its origins to the concept of the 'good enough' parent whose role is to provide, inter alia, stimulation, sustenance and support. Hence we consider the partnership in similar terms -- what is it that sustains it and helps it thrive and realise its potential?

Warne and Howarth draw on the work of Brown et al (2006) to set out 8 factors which contribute towards sustenance and, as mentioned earlier, upon which our interview questions were based. The following is freely adapted from Warne and Howarth (2009: 47-49).

Right reasons -- having a shared vision of what might be possible through partnership working and ensuring a long-term focus.

It has been evident from the data presented in Section 4 that a fundamental problem in studying this group was the lack of clarity over its purpose. Was it a forum for getting together and sharing ideas; part of the structure whereby Impact managed its projects; or a way of identifying the need for health based interventions and responding to them?

"It was sharing what was happening, what [Impact] was doing and what other agencies and groups were doing and how support and interaction can be created between them" (INT i)

"It was around promoting health in its very broadest sense for that particular community" (INT iii)

"It's helpful for networking… a forum where partners can come together" (INT viii)

"I was never 100% clear what the function of the group was" (INT vi)

"It wasn't clear exactly who should be there" (INT vii)

"It was about identifying the needs of the Impact area and monitoring how programmes were being delivered and how that was impacting on the health targets in that area" (INT v)

In many ways it was clearly all 3 and seen as such by some participants but there were no of terms of reference or a clear statement of outcomes.

High stakes -- compelling reasons for individual members to ensure that the partnership is successful (more than it just being 'a good thing'). Might involve agreement on processes but desired outcomes are a crucial aspect.

The Warnwarth framework eschews being 'a good thing' as a legitimate role of partnership but there seems little doubt in the case of this group that its mere existence was valuable for many members who saw loose 'networking' as an important function, frequently with positive outcomes.

"You think 'oh yeah they could help with that' or, you know, 'we could support them with that'. Or 'they're thinking that way as well so we could support their project because we do this'" (INT viii)

"I think we shared information which is very important and for the projects we were involved in we could say 'Ah, then you need to make connections with this or that group, this is somewhere you could refer people on to if they had a good idea about how to do something'. So I think that was probably a benefit" (INT ix)

In part this was due to most members having contacts outside the group and being familiar with each other. That said, actual investment in the group was hard to assess.

"I think it's hard to get people to commit you know. [The leader] has invited, say, senior public health managers who were not regular attenders but maybe that's because it's a mixed group of providers so then people think 'is this for me?' you know because many of the people there are actual community workers themselves" (INT v)

And one interviewee was clear that there needed to be a clear sense of purpose

"People do go to meetings and they just 'have the meeting' but there's not really any clear action… there are things to be done and people need to take responsibility at all levels. I think there's this thing about partnership and it's all kind of lovey-dovey and somehow by some kind of osmosis we'll understand each other but I don't think you do. Partnership is about more than having meetings" (INT ix)

Right people -- Have the best and most appropriate people and sufficiently empower them to have a reasonable degree of autonomy. Issues around appropriate and equitable representativeness need to be addressed.

"The [health and social care] group itself is quite disparate, lots of different people involved in different projects (...) with some people over a short period and some having quite a long period in it" (INT ii)

"…didn't always get consistent attendance to those kinds of meetings. There is also a short-term project phenomenon where some are only funded for a year or so, so it's very hard actually to get things going in that time. So for the health and social group you lose continuity and it's a bit fluid" (INT ix)

Continuity was to some extent a function of the short-term nature of some projects and there is an implied disadvantage in having both operational and strategic people together. However different people with different functions can still be the 'right people' providing the goals are clear and people know what their roles are:

"I think you have to look at 'what do we want to achieve?' and then get the right people there. Now that might be a range of people. It might be community representatives who don't hold a lot of strategic power but they carry the information; it might be people who are working in and leading projects, and then it might include people who also carry strategic power as well. I think that can work as long as everyone is clear about what their role is" (INT x)

Such a mixture was seen as a positive advantage in the workshop, referred to in Section Four.

There were some conspicuous omissions; there was no one from social services and community involvement was elusive. While seen by Government as an imperative it is ill-defined and:

"*Even the successful partnerships continue to struggle with issues such as community linkages…and the challenge of how to ensure ongoing community voice and community accountability*" (Alexander et al, 2003: 141S and 152S)

The usual model just seeks involvement from representatives of 'community organisations' but one interviewee was much more positive and pro-active:

"*There are many within the community and in small groups which could become part of the social enterprise and who we need to reach and we know who they are and that they are hungry for this sort of thing*" (INT i)

Again, we find that the situation is more complex than the framework appears to allow because the informal connections permeating the boundaries of even such a loose group as this can be very productive in influencing its work.

Right leadership -- Identified in nearly all evaluation instruments and assessment tools as possibly the most crucial element in achieving effective working. Need to foster respect, trust inclusiveness and be flexible in style and approach.

The leader was explicitly, and incontrovertibly, the representative from Impact who organised the meetings and produced the agenda. Everyone saw this as entirely natural largely because the

projects represented on the group were all funded through Impact.

"*I think [the leader] is a very good chair… a very good atmosphere, it was really nice and it was usually over lunchtime so we got there and there was something to eat which -- you can't beat it. And we share communally. And you can have a bit of a chat at the meeting which is well organised with an agenda. I think people felt OK*" (INT ix)

"*It is difficult for her because we are such a different group of people but that's the skill of partnership working I think, or networking. It's to get the common interest from the group of very different people who work at very different levels within organisations*" (INT vi)

Much depends on the character of the leader concerned and there would have been ample scope here for things to go wrong. What we learned is that even where the leader comes from the organisation which holds all the funding it is possible to lead the group effectively and sensitively.

Strong, balanced relationships -- Need to ensure that relationships are managed, nurtured and supported recognising issues around imbalances in power which need to be addressed sensitively with an awareness of different organisational cultures represented within the partnership.

Again this reflects the character of the leader but 'having the power' does not have to be explicit or oppressive without nevertheless having a strong influence on the way the group operates. We asked whether some members got more out of it than others:

"*Yes I suppose coming in, and being quite new, I felt very comfortable that I could speak to everybody, I could say what I thought and I think a lot of that is because I've known [name of leader] for quite a long while, a few other members that I knew so I felt quite comfortable in that setting*" (INT viii)

Relationships built up outside the group are frequently influential and the converse can be the case:

"*We didn't have other contact and that may have been one of the reasons why things were not as easy as they could have been in terms of developing good partnership working*" (INT iii)

"*In the health and social care group there isn't any feeling of hierarchy, there is a feeling of relationship a feeling of support and that for me is what partnership work is about... how else do people establish networks, it is quite hard to do that just by going out and knocking on doors but that intelligence already exists, a group of people come together so somebody will know somebody or will ask questions and somebody already knows the answer so we get that and we get sharing*" (INT v)

Trust and respect -- All contributions need to be valued and respected regardless of levels of responsibility. This takes time.

Most of the issues here have been referred to already, particularly those to do with valuing all contributions. This was ascribed to the commitment of the leader.

Good communication -- Individual members need to ensure within their organisations and across the partnership that communication is open as possible. It also means that group members should feel able to communicate ideas and criticism in safety.

Group members feeling 'able to communicate ideas and criticism in safety' seems to overlap with 'good leadership' and the 'trust and respect' agenda but there is another important element identified in the framework to do with communication outside the group.

"It would have been good [for me] to have been managed in a way that said 'Right [name of respondent] you're going to go there and I want a report every month because I'm taking this to the partnership group with the local authority and I'm going to take this to the director of the board of the primary care trust" (INT x)

Formalisation -- Even simple partnerships required governance structures which need to be constantly reviewed to ensure the partnership can endure and survive beyond the active participation of individual members.

We have already referred to the absence of terms of reference or explicit goals beyond the general one of improving the health and well-being of the community. Nevertheless there was some effective working for the reasons discussed above. What came across very strongly was the skills and personality of the leader and yet:

"If somebody new were to come and replace [the leader] tomorrow I think that we would struggle because it's someone coming with probably fresh ideas, looking at it differently, and then it's going to take a year or something to them to get up to speed in which case you lose momentum" (INT ii).

Although we have focused on the responses in the context of the framework, and will be discussing these in more detail later, this was a loosely structured group and we specifically asked people about how it fitted into their concept of partnership. The term 'networking' frequently appeared, sometimes interchangeably:

"There is a feeling of relationship, a feeling of support and that for me is what partnership work is about, how else do people establish networks" (INT v)

or complementary

"To me it was a network but partnership working was taking place within and between the organisations who met" (INT i).

as a precursor

"… I think partnership is about the outcome of networking" (INT v)

or operating at a different level altogether:

"You have to be clear what you're trying to achieve from the partnership and have an expectation of how the partnership is going to work. If it is just about networking that's fine but if it is about signing up to, you know, investment and resources then that's a different sort of kettle of fish" (INT vi)

One respondent alluded to the group being a different sort of generic partnership – community v organisational

"It was a partnership but a community partnership sometimes operates differently from an organisational partnership. Community partnerships you can change -- if something is not going well, as time goes along you can bring new partners in and change things and you can keep it going provided there is someone there to oversee it all. Organisational partnerships means you have to fit in to a big structure" (INT ii)

However, popular notions of, and criteria for, partnership applied, whatever label was attached

"For me partnership working means common commitment to something that you're trying to do and that's what we've had with the group…[which] is a really good example of partnership working as people are actively involved in the same thing so everybody's contributing expertise and their commitment. They might have a different role to play but they're contributing that to the health and social care group. We could all be doing that individually but the benefit by coming together is around delivering services that are more likely to complement one another than being in competition with one another" (INT v)

"Partnership working is all about having shared vision and values to which everybody is signed up… it helps you as a representative of your organisation deliver on targets" (INT vi)

Discussion

This research was both conventional in its evaluative and analytical role but also proactive in stimulating and assisting change. In each case we drew on similar data but used them in a different way. This makes for a complex report; to meet the aims of the Urban Regeneration programme (as set out on page 3) we needed to develop "a distinctive form of knowledge transfer, which is both teaching and research driven, in order to meet the needs of organisations and professionals in business and the community." Hence the research had to be seen as being of practical and tangible benefit to the participants, and stimulating to their partnership development. However it also needed to contribute towards developing an evaluation package for partnerships, based upon the Warnwarth framework, which could be used on a much wider scale. Here too we had different, but complementary, aims. While we used the framework to design our interview questions and see how far the group met its criteria, we also used material from our research to critically evaluate the effectiveness of the framework itself in identifying a 'good enough partnership' and to make suggestions for its further improvement.

In considering the effectiveness of the Warnwarth framework, we liked the terminology - 'good enough partnership' - because it recognises the possibility that a partnership might only satisfy some of the framework criteria to a limited degree and yet be good enough for the task; i.e. it is assessed in the context of what it is trying to do. Part of the problem with our case study was that, apart from a broader aim to improve

health and well-being, the aims of the group were not specified so what was it good enough for?

Firstly, it was good enough for getting together people working in health and social care so it did get the 'right people' with some notable exceptions such as the social services department and much in the way of community involvement. Its mix of operational (mostly of projects funded by Impact), and strategic, participants was seen to be desirable and will be perpetuated in whatever new form the group takes.

Secondly, it facilitated networking in what seemed a very positive sense where there was an active commitment to learning from each other and offering collaboration.

Thirdly, it provided a support and development function to practitioners by generating a climate wherein what were often small-scale, and potentially isolated, projects could share common professional interests and locate themselves within the broader objective and philosophy of improving the health and well-being of their local community.

The ability of groups to work in this less structured way is not unusual and was noted by Molyneux from the perspective of an interdisciplinary team setting:

"Team members clearly felt that the lack of established criteria and guidelines was ultimately helpful, in that staff were able to work creatively together in devising their own guidelines and methods of working around the needs of this particular team" (Molyneux, 2001: 32).

Some participants felt that more could have been done to offer development advice and support, particularly in accessing funding beyond that available from Impact itself and in 'mainstreaming' some of the activities and practices.

Why, therefore, did this partnership survive even though funding was running out and the obvious financial benefits of being associated with the group diminished?

We certainly agreed with the framework on the importance of leadership and felt that some of the other aspects -- strong, balanced relationships and a culture of trust and respect -- stemmed from this. We wondered whether the interdependence of these features needed to be taken more account of in the framework. The role of leader here was an interesting one because the staff member of Impact, which convened and managed the group as well as funding the projects represented upon it, was likely to be endowed with a great deal of power. However none of the respondents was critical of this, seeing the leadership role as a 'natural' one and its exercise of power as sensitive and even-handed. This is not an easy task given the mix of practitioners and managers, some of whom were well established and represented the major 'players' in the locality, while others were from small, often transitory, projects. Robinson and Cottrell (2005: 555) warn "that such 'minority' members may feel disempowered", which was clearly not evident in this group.

There is another element here and that is the longevity and continuity of the group under the same leadership. Hence it is important to see a partnership like this one in its local context as part of a long-standing regeneration activity where everyone knows everyone else and that what goes on outside the 'partnership' may be as important as what goes on within it. It was evident from the workshop, and from the interviews, that there was a reservoir of goodwill, expertise and commitment accumulated over several years and sustained through consistent and facilitative leadership.

Alexander et al (2003: 130S) consider that "sustainability is a key requirement of partnership success and a major challenge for such organisations". It was an important strand in our research because of the metamorphosis from NDC to a social enterprise. The framework does not specifically address sustainability, other than by implication, which we think needs addressing explicitly. An important factor in exploring sustainability with a partnership is determining what it is that will be sustained -- whether it is the projects and activities connected with the group or its values and tradition. In our research the group is in the process of changing its format, and its task, building upon issues which arose in the research and upon which we initiated discussion in the workshop. The key outcome for them was to sustain, in the new format, the habit of collaboration and the personal relationships developed in the group.

Where we did have difficulty in satisfying an aim of the research, was in assessing what factors within the partnership contributed to improved health and well-being. There was certainly a general sense that the associations developed through the group, the mutual support and advice, together with sharing and developing strategies, contributed to the success of each project and therefore to a successful outcome. From a methodological perspective, the causal processes -- what it is within the intervention which directly influences health – is highly complex and trying to deduce the role which the partnership itself plays in the process is equally problematic. However, several interviewees thought the partnership could have played a more proactive role in identifying particular areas for health improvement intervention and used its accumulated expertise and cross-agency relationships to attract and coordinate the appropriate resources. This is likely to be an expectation in the new partnership which is being discussed.

In many ways this group was an unusual one but, using the framework, we were able to explore many aspects of collaborative working which might not have otherwise emerged. We found a sophisticated use of a partnership which went beyond satisfying formal goals but, through interaction of the partners, supported, stimulated and facilitated their activities. Hence there were 'layers' of cooperation within the partnership and informal networking was one of the layers. The framework does not, in our opinion, recognise this informal role in a partnership or that it may be,

in itself, 'a good thing' even when it is not clearly linked to robust outcomes and structures. This may be why there was a preference for the term 'network', because partnership, for some, implied something more formal and structured.

However, network itself was seen either as coterminous with partnership, a precursor to it or something quite different and more lightweight. Interestingly, the latter definition came from one of the principal agencies and "big players" in the partnership where preference for a more structured and accountable organisation is understandable. In exploring the concept of networks further we were attracted to Newman's work on the dynamics of partnership (Newman, 2001: 114). She appears to look for tendencies (rather than criteria) in her four models; towards pragmatism (emphasis on getting things done, meeting targets); towards accountability (emphasis on structures, roles, procedures); towards flexibility (adapting to changing conditions, expansion); and towards sustainability (fostering participation, building consensus, embedding networks). The Health and Social Care Group tends, on these criteria, towards flexibility and sustainability which seem appropriate given the evidence we have gathered. We think the framework would benefit from considering the above work and finding some way to incorporate it, or at least its principles; they share a postmodernist foundation, preferring loose and wide-ranging, rather than rigorous, definition.

Summary

This research has encountered aspects of partnership working which rarely feature in the literature but which are to do with informality, continuity and a commitment to improving people's lives through sharing and collaboration. We believe that this is an arena some distance from the formal, structured and conventional partnerships upon which policy is founded but which represents the day-to-day experiences and reality for those working in the field of regeneration.

The research was of practical use to the participants in helping them to begin to shape the future role of the partnership to meet the changed circumstances:

- The role and function of the group needed to be clearer, with terms of reference known to all

- Group membership should be reviewed to reflect its role and function and should include social services and local government staff as well as community representatives

- How the group links in – or could link in – with other partnerships needs to be established to ensure it meets a need not provided by other organisations

- That the strong leadership of the group be maintained and consideration given to succession planning for if or when the current leader is no longer in this role

As a first step the group proposed reconstituting itself as the Impact Health and Wellbeing Partnership (working title) which would

- Act as an umbrella organisation for all health and social welfare projects operating in the locality

- Have responsibility for identifying health and social care needs and advocating these with funding bodies (PCT, local authority)

- Provide advice and help on accessing funding

- Act as a link with, and voice of, community groups and individuals (one of our suggestions in the presentation)

- Reflecting the goals and strategy of the LA at the local level (which is currently a very grey area)

The Warnwarth framework was a valuable research tool in enabling us to access the subtle relationships within this partnership and identify its strengths and accomplishments. Learning from the research has enabled critical examination of some of the assumptions of the framework and suggested further aspects to consider:

- The importance of the continuity and history of partnerships

- Explicitly address 'sustainability'

- The local context in which partnerships operate

- The significance of partners' relationships outside the partnership

- The complex aspects of the role of leader and the use of power

- The 'networking' feature in partnerships

- Informality

- Acknowledge more explicitly the interdependence of some of the framework aspects

- The potential to engage with Newman's work on the dynamics of partnership.

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Appendix 1

The 'Warnwarth' Framework

(A précis of the principal features from Warne and Howarth (2009).

Right reasons -- having a shared vision of what might be possible through partnership working and ensuring a long-term focus.

High stakes -- compelling reasons for individual members to ensure that the partnership is successful (more than it just being 'a good thing'). Might involve agreement on processes but desired outcomes are a crucial aspect.

Right people -- Have the best and most appropriate people and sufficiently empower them to have a reasonable degree of autonomy. Issues around appropriate and equitable representativeness need to be addressed.

Right leadership -- Identified in nearly all evaluation instruments and assessment tools as possibly the most crucial element in achieving effective working. Need to foster respect, trust, inclusiveness and be flexible in style and approach.

Strong, balanced relationships -- Need to ensure that relationships are managed, nurtured and supported, recognizing issues around imbalances in power which need to be addressed sensitively with an awareness of different organisational cultures represented within the partnership.
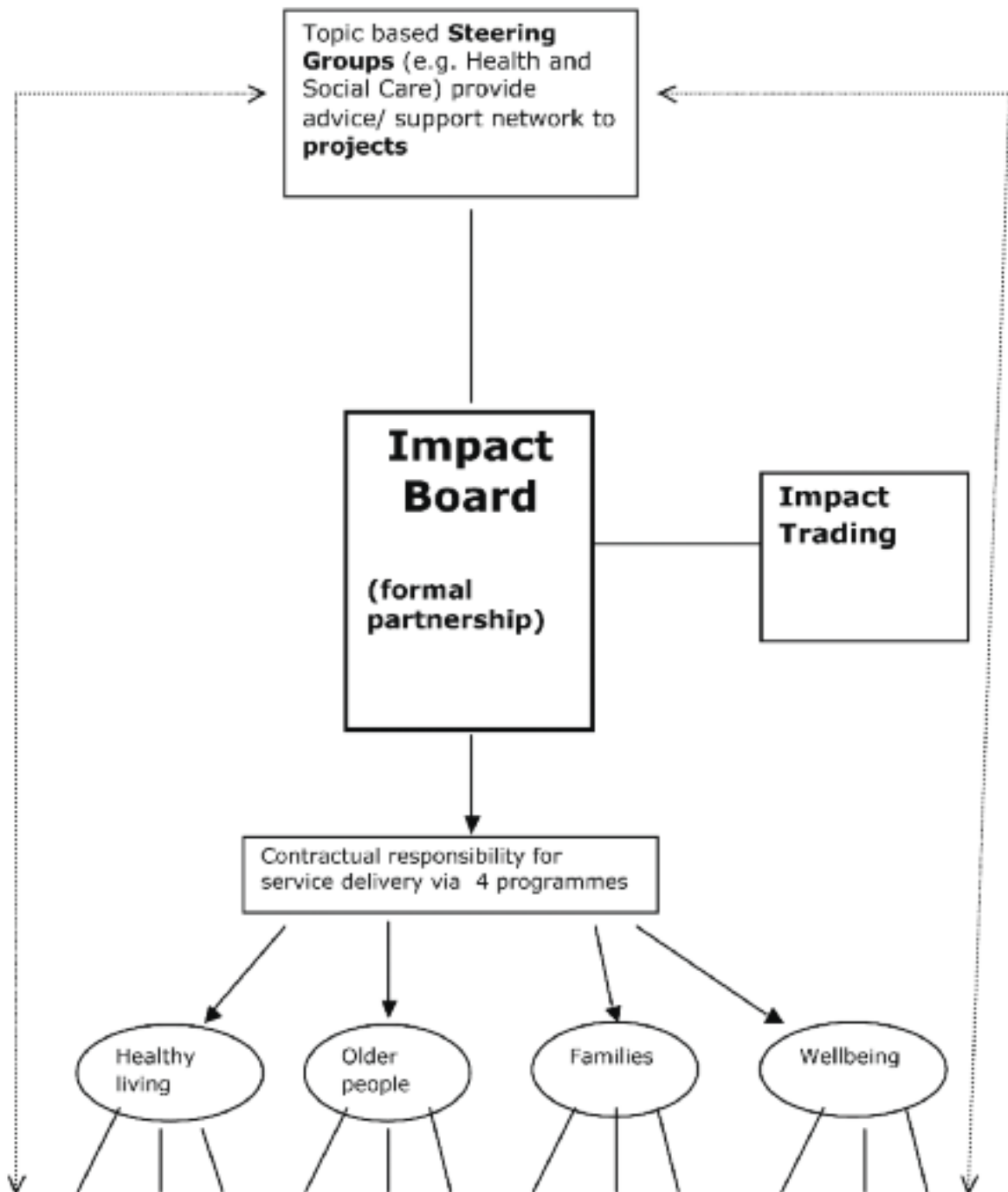
Trust and respect -- All contributions need to be valued and respected regardless of levels of responsibility. This takes time.

Good communication -- Individual members need to ensure within their organisations and across the partnership that communication is as open as possible. It also means that group members should feel able to communicate ideas and criticism in safety.

Formalisation -- Even simple partnerships require governance structures which need to be constantly reviewed to ensure the partnership can endure and survive beyond the active participation of individual members

Appendix 2

Schematic Structure of Impact Programme Delivery Model

Topic based **Steering Groups** (e.g. Health and Social Care) provide advice/ support network to **projects**

Impact Board

(formal partnership)

Impact Trading

Contractual responsibility for service delivery via 4 programmes

Healthy living

Older people

Families

Wellbeing

Notes

Chapter 4 Explicating the role of partnerships in changing the health and well-being of local communities: A New East Manchester Case Study

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Contents

Introduction

This case study has adopted a participatory action research framework to understanding the role of partnership-working through collaboration between regeneration professionals and local residents within an area of regeneration. This chapter focuses on shared learning, experiences and understandings of regeneration professionals and local residents to enable a better understanding of how partnership-working for health and well-being has been articulated within a regeneration area of the North-West. The work undertaken and data collected through this case study constitutes a wider Urban Regeneration Making a Difference Grant entitled : Understanding Health and Well-being: A Participatory Action Research Approach.

This case study is located in the regeneration area of East Manchester which since 1999 has received large amounts of investment through the Urban Regeneration Company, New East Manchester. The funding has led to significant physical transformation of the area as investment has been channelled through key development frameworks which have led to the implementation of a number of physical, social and economic regeneration programmes. It is through this investment that the urban regeneration company has intended to improve the health and well-being of local residents based upon a number of key performance indicators aimed at tackling major health determinants. New East Manchester's strategic vision aims at improving quality of life for residents, as well as creating a vibrant, liveable place where people aspire to live and work through long-term sustainable regeneration. An independent evaluation of the regeneration programme revealed that significant progress has been made to alleviate deprivation across the area,

"New East Manchester is making great progress… it has already delivered many of its key projects across its strategic ambitions and is on course to deliver many more" (EIUA, 2007, p.23).

The evaluation report highlights that improvements have been made across diverse range of health and well-being determinants including community cohesion, housing conditions, educational attainment, and economic prosperity across the region (EIUA, 2007,). Other research, whilst not focussing on New East Manchester per se, has been more critical of regeneration initiatives in the UK as being to focussed on physical transformation; a focus which can have deleterious effects on the social well-being of local residents. Here, feelings of community detachment, exclusion and placelessness can arise (Brown et al, 2003; MacLeod and Ward, 2002; Lees, 2004).

Further debate has centred around collaboration and partnership-working with the local community. A core objective of the regeneration strategy has focussed on community engagement and participation through partnership-working which encourages local people to help shape and deliver regeneration initiatives. Here, regeneration policy has been centred on 'strengthening communities' and the need to ensure that local people have the "skills, knowledge and abilities to effectively engage in their area" (New East Manchester, 2001). The document prioritises the need for community facilities which are designed, implemented and sustained by the local community. Despite government policy promoting capacity-building within the local community (CLG, 2006, 2008) the delivery of regeneration practice across the UK

has achieved mixed results in legitimising local residents and empowering them through the decision-making process (Diamond, 2004, Dinham, 2006). New East Manchester, considers the "community" to be partners in the design and delivery of services in the area. Consultation, engagement and building skills within the community have been a recurring element of the regeneration frameworks for the area (New East Manchester, 2000, 2008).

Using the Warnwarth conceptual model for partnership-working (Warne and Howarth, 2009) this case study undertakes a participatory action research approach to understanding the issues which have emerged from the partnership-working between regeneration professionals and local residents. This case study does not analyse a specific formal partnership, rather it provides a critical reflection of the power imbalances and the differing notions of health and well-being, engagement and participation between the 'resident' and 'professional' communities.

The objectives of the study were to:

• Explore professional and resident conceptualisations of health and well-being through the regeneration;

• Understand how health and well-being is articulated within the regeneration process;

•Investigate the role of resident participation and engagement as a form of partnership-working between the 'resident' and 'professional' community;

• Begin the process of shared visioning through an action research event aimed at sharing knowledge, learning and experiences around partnership-working and to generate recommendations for policy and practice

2. New East Manchester – A Regeneration Vehicle

The delivery system of regeneration within the UK consists of neighbourhood renewal and regeneration programmes, area-based initiatives and EU funding being used alongside mainstream public services and investment from the private sector with the aim of alleviating multiple deprivation in inner city areas. A key recommendation from the "Bringing Britain Together" report (SEU, 1998) and the "Lord Rogers Urban Task Force Report" (Urban Task Force, 1999) was for a single organisation (urban regeneration companies) to instigate a coherent single vision for an entire area and then co-ordinate and oversee its implementation. As a result New East Manchester Urban Regeneration Company was established with the lead responsibility for delivering a long-term strategic holistic vision for physical, social and economic change within that area of the city.

The partnership brought together national, regional, and local government to work along side the local community to ensure complimentality, additionality and a coherent approach to both public and private sector investment.

As the problems facing East Manchester were predicated upon complex socioeconomic and environmental factors, a comprehensive and integrated approach was undertaken, central to which is the development of partnerships with local organisations, the private sector voluntary bodies and community representatives. New East Manchester brings together a number of the Government's area-based initiatives, which have been designed to address the problems of urban deprivation.

These, amongst others, have included: Housing Market Renewal Programme, Surestart Programme; Health, Education and Sport Action Zone initiatives. It also encompasses the New Deal for Communities (NDC) and Strategic Regeneration Budget (SRB) initiatives otherwise known as 'Beacons for a Brighter Future' in East Manchester.

Community engagement is a major feature of the programme, with an emphasis on community 'ownership', the importance of joined-up thinking, partnership working and service delivery and the integration of mainstream activities. The New East Manchester focus is to achieve long-term results, which will narrow the quality of life gap between East Manchester and the rest of the country (New East Manchester, 2001)

Regeneration geography in East Manchester

The New Deal for Communities programme has contributed significantly to the regeneration of the Beswick, Clayton and Openshaw areas of East Manchester through a combination of Government, mainstream and private sector funding, including the £51 million NDC and £25 million SRB programmes. As a result significant progress has been achieved across key parameters including crime rates, educational attainment, employment status and measurable health. Additionally, notable improvements have been made to local housing, as a consequence of the recognition that many of the problems associated with deprived areas, including the quality of the area and health outcomes, are directly linked to housing conditions (ODPM, 2005). Integral to this was the need to manage housing transformation within an area characterised by a high proportion of social housing which typically suffered from multiple problems (poor housing conditions, social and economic problems). The Decent Homes Standard was a result of the Housing Green Paper published in 2000, which called for "quality and choice: a decent home for all" (DETR, 2000).

A recent evaluation of the New East Manchester regeneration programme has commended the regeneration area on achieving improvements across a range of health and well-being determinants including reduced levels of crime, higher educational attainment and increased employment. Furthermore, the regeneration was seen as successful in establishing partnerships through "extensive collaborative working" across the programme, whilst effectively engaging and consulting with the community through the resident liaison team and existing ward co-ordination structures (EIUA, 2007).

Photographs A and B: New Housing Stock in East Manchester

Beacons, supported by the ODPM Manchester Housing Market Renewal Pathfinder (ODPM, 2003) scheme has been active in regenerating housing stock in the area of East Manchester, integrating: (i) social justice and living standards (ii) increased economic competitiveness of poor areas and their residents and (iii) improved social cohesion through housing diversification. The provision of better housing quality and management is intended to provide direct quality of life benefits to local people; stabilise existing populations and attract new residents; reduce stigma and lever in private sector investment. This has also involved a rigorous programme of reinvestment in existing stock (repairs, renovation and up-grading) to ensure that all homes now meet

the governments Decent Homes Standard required by 2010. The intention of the housing market renewal scheme was to change the social mix of deprived areas as a tool for achieving improved social outcomes (Kleinhans, 2004). Urban regeneration policy has argued that mixed tenure is vital to improve social integration and sustain neighbourhood facilities in order to create regeneration that lasts (DETR, 2000). However, some research suggests that the principle of housing market renewal is predicated upon a process of social engineering, which demonstrates a shift from socially oriented targets towards housing market and housing career milestones (Tunstall, 2003). It has been suggested that such policy lacks a clear operationalised definition of social cohesion and underestimates the importance of the 'community', which is a place for building social capital, woven together by deep-rooted social networks (Forrest and Kearns, 1999, 2001).

Furthermore, research indicates that place is more intimately connected to people and that housing policy, through displacement, can disrupt community cohesion as it fractures the intimate relationships between people and place (Lees, 2004). The dynamics between people, place and determinants of health and well-being have been well explored (Macintyre et al, 2002), providing evidence to suggest that regeneration policy, through physical transformation, has a significant part to play in creating 'places' which are the context for improved health and well-being. Although research has been conducted on linking the concept of place to the notions of health settings and well-being, little attempt has been made to situate this within regeneration.

3. Deprivation in East Manchester

East Manchester was formerly the hub of industrial activity in the region, but started to experience serious economic, social and environmental decline in the last quarter of the twentieth century. Subsequently, the area suffered physical decay, with many derelict buildings and large areas of vacant and degraded land characterising the area. Population numbers declined as Census results evidenced a 13% reduction in population across the New East Manchester/Beacons area between 1991-1999, despite the rest of Manchester growing by 3.5% during this period (New East Manchester, 2001). Vacant housing became a key problem in the area, as the value of housing stock declined five-fold in ten years (New East Manchester, 2001). These problems perpetuated in a poorly educated, unskilled workforce, with little or no aspirations for the future.

Demography

Analysis of the background data reveals that the household composition of New East Manchester/Beacons area has revealed that 16% of a population of just under 63,000 are of pensionable age, compared to just under 14% for the rest of Manchester (ONS 2005, Mid-year estimate). Indeed, the percentage of the population under 16 stood at just under 22% compared with just under 19% for the rest of Manchester (ONS 2005, Mid-year estimate) revealing a smaller percentage of the potentially economically active age group (16-64) and thus possible lower levels of economic activity. The ethnicity of New East Manchester/Beacons area demonstrates that as of 2001 90% of the population were White British, with small minorities of Asian British, Black British and Chinese.

The ethnicity make-up of the rest of Manchester reveals just over 80% are white (Census, 2001).

Health

Extrapolation of the health data reveals that in 2001 over 26% of the population had a limiting long-term illness, exceeding the rest of Manchester (22%) and national levels (18%) (ONS, 2001). Despite commendable reductions in teenage conception rates, they still remain far in excess of Manchester and the rest of England (NEM KPI Report, December 2006). The percentage of low birthweight babies exceeds 13% in some wards, compared to 9.4% in the rest of Manchester and 8% in England and Wales (ONS Birth Extracts 2001-3; ONS VS1 Table 2003; NEM KPI Report, December 2006). Furthermore, returned data for the wards of the New East Manchester/Beacons area reveals a mortality rate that is far in excess of the rest of Manchester (ONS Annual District Death Extracts (ADDE) 1998-2002; 2001 Census).

Education Attainment

The educational attainment of the residents of New East Manchester/Beacons reveals that 51% of the economically active population have no qualifications, compared to 34% of the rest of Manchester and 29% nationally (Census 2001). Unsurprisingly, attendance figures at both primary and secondary school level are below that recorded nationally, albeit showing signs of significant improvement across the whole of East Manchester (NEM KPI Report, December 2006). Such findings suggest that the low aspirations and stifled ambition of the residents of New East Manchester/Beacons precipitates to the younger age groups.

Regeneration projects set up as a result of the New East Manchester education programme have been aimed specifically at educating younger people, including aspects of aspiration building and raising the self-esteem of younger people.

Employment and Benefits Claimants

Despite reductions in unemployment since the regeneration began, unemployment in New East Manchester/Beacons still stands at 6.2%, compared to 3.9% for Manchester and 2.8% for the rest of the North-West (NEM KPI Report, December 2006). Of the economically inactive nearly 30% are permanently sick or disabled, compared to a Manchester percentage of 21.5% and a national figure of 16.5% (Census 2001). Of those employed 35.5% are in lower supervisory or routine occupations, which exceeds that in the rest of Manchester (25.5%) (Census 2001). Manufacturing still accounts for a relatively large percentage of employment in the area, with under-representation in the professional services sector. The percentage of benefit claimants in New East Manchester/Beacons remains stubbornly high, with just under 12% of working age residents claiming incapacity benefit, compared to just over 8% for Manchester and 4.5% for England and Wales (NEM KPI Report, December 2006). Nevertheless, a number of projects and initiatives established as a result of the regeneration's economic programme have focussed their work on ensuring the long-term involvement of residents in education and long-term employment.

Crime and Housing

East Manchester performs positively on available data pertaining to actual crime. Actual vehicle theft has halved in New East Manchester since 2000 (NEM KPI Report, December 2006) and reported burglary (6.89/1000 households) is now lower than the rest of Manchester (7.8/1000 households). Addressing aspects of crime and safety and youth intervention are the initiatives undertaken as part of the regeneration's crime and community safety programme. Housing tenure data for New East Manchester/Beacons reveals high levels of social rented properties - 38% of existing stock is rented from the council, compared with the rest of Manchester at 28.5% and just over 13% nationally (NEM Implementation Plan, 2005). Additionally, there are still large amounts of reported vacant housing stock as whole streets, apart from one or two properties, stand empty and abandoned (NEM Implementation Plan, 2005).

Index of Multiple Deprivation

The Index of Multiple Deprivation (IMD 2004) is a composite of seven separate domain indices which are: income; employment; health and disability; education, skills and training; barriers to housing and services; crime and disorder; living environment. The IMD reveals that the area of New East Manchester/Beacons performs poorly, with 21 of the 38 super output areas of East Manchester finding themselves in the bottom 1% of the country (Oxford University, 2006).

4. New East Manchester and Partnership-working

This study contributes to a key aim outlined in the New East Manchester Regeneration Framework for the area which emphasised the need for Community and Capacity Building, which focuses on 'strengthening communities' and the need to ensure that local people have the "skills, knowledge and abilities to effectively engage in their area". The document prioritises the need for community facilities which are designed, implemented and sustained by the local community:

'The key to ensuring that community facilities continue to meet demand of the local communities is to encourage community ownership and maintain long term flexibility in the context of the core principles in terms of provision' (New East Manchester, 2001).

The recent Strategic Regeneration Framework for the area re-emphasised the need to focus on creating neighbourhoods and places which are responsive to the needs of local people. Working in partnership with the local community is seen as integral to the creation of vibrant, good quality and well used places which are 'recognisable' and 'sustainable' as opposed to "fragmented communities of varying degrees of stability" (New East Manchester, 2008, p.72).

New East Manchester's strategic vision aims at improving quality of life for residents, as well as creating a vibrant, liveable place where people aspire to live and work through long-term sustainable regeneration. An independent evaluation of the regeneration programme revealed that significant progress has been made to alleviate deprivation across the area, "New East Manchester is making great progress… it has already delivered many of its key projects across its strategic ambitions and is on course to deliver many more" (EIUA, 2007, p.23). The evaluation report highlights that improvements have been made across diverse range of health and well-being determinants including community cohesion, housing conditions, educational attainment, and economic prosperity across the region (EIUA, 2007,). Other research, whilst not focussing on New East Manchester per se, has been more critical of regeneration initiatives in the UK as being to focussed on physical transformation; a focus which can have deleterious effects on the social well-being of local residents. Here, feelings of community detachment, exclusion and placelessness can arise (Brown et al, 2003; MacLeod and Ward, 2002; Lees, 2004).

Further debate has centred around community participation as articulated within regeneration policy and the impact of participation processes on local residents' health and well-being. Despite government policy promoting capacity-building within the local community (CLG, 2006, 2008) the delivery of regeneration practice across the UK has achieved mixed results in legitimising local residents and empowering them through the decision-making process (Diamond, 2004; Dinham, 2006). The regeneration company, New East Manchester, considers the "community" to be partners in the design and delivery of services in the area and consultation, engagement and building skills within the community has been a key facet of the regeneration frameworks for the area (New East Manchester, 2001, 2008).

Whilst the concepts of community engagement and well-being are wedded together in urban regeneration policy, substantial literature indicates that the concepts of 'well-being' and 'participation' are both complex and multi-faceted (Haworth and Hart, 2007). It has been theorised that "the concepts of well-being and participation share an obvious similarity: they are both highly contested, internally diverse, umbrella terms" (White and Pettit, 2002, p.2).

As such, it is not appropriate to consider the concepts of in isolation rather there is a direct relationship between the two notions, where it is suggested that *"inherent in the concept and practice of participation… is the assumption that participation will enhance well-being"* (White and Pettit, p.2). Participation is seen as crucial to feelings of self-determination, personal fulfilment, and making a positive contribution, which are considered key facets of individual development and human flourishing (Shah and Marks, 2004).

Dinham (2006 p.182) argues that *"community participation is the key i n laying the foundations for well-being".* Community participation is seen as vital to the long-term sustainability of regeneration programmes where continuous service improvement can only be fully achieved when local people are engaged in the regeneration process and where regeneration policy is successful in putting local people "in the driving seat" (SEU, 2001, p.5). This requires effective partnership-working between regeneration professionals and the local community to facilitate shared dialogue, devolved decision-making and community empowerment.

This drive towards local co-ordination and collaboration also necessitates a collective effort between the regeneration company, public sector agencies and the local community, with the local authority as drivers of change. This was embodied within the Local Government Act 2000, which called for local authorities to produce Community Strategies/Plans. These plans gave local authorities the power to undertake anything which is *"likely to promote or improve the economic, social or environmental well-being of the area"* (Local Government Act, 2000, ch 2 pt I) with the engagement and participation of local communities being central to the process. The effective engagement of local residents is seen as vital to creating places which are designed and sustained by the local community, bringing about a sense of identity, familiarity and community belonging (Meegan and Mitchell, 2001).

Resident involvement in the creation of new community places enables the optimisation of place-based functionality and provides the conditions under which the physical environment can become psychologically and socially meaningful. Conversely, physical change which is sudden or seen as enforced can bring about feelings of alienation, placelessness and exclusion when local people do not feel that they are engaged or actively participating in the regeneration process (Loukaitou-Sideris, 1995).

5. Methodology

A mixed-methods approach was adopted to the data collection phase of the study consisting of: semi-structured interviews with local residents (n=15), regeneration professionals (n=18) and service providers (n=8) followed by an action research event with local residents, regeneration professionals and academics. A mixed-methods approach was used as it enabled a broad range of research techniques to provide breadth and depth to the experiences of both the 'resident' and 'professional' community. Kaplan and Duchon (1988, p.575) suggest that *"collecting different kinds of data by different methods from different sources provides a wider range of coverage that may result in a fuller picture of the research problem… it provides a richer, contextual basis for interpreting and validating results"*. Semi-structured interviews were undertaken to explore everyday understandings of health, well-being and regeneration within the context of engagement, collaboration and partnership-working from the perspectives of both local residents and the 'professional community'. The findings were then used as the basis for shared dialogue and learning through an action research event conducted with the 'resident' and 'professional' community.

An action research event was conducted as part of the research project, which brought together local residents (n=12), regeneration professionals (n=12), service providers (n=7) and academics (n=13) to engage in a process of shared learning and reflection. A knowledge café approach was undertaken for the workshops stage of the event, which engendered an open and creative atmosphere for the workshop discussion. In general, knowledge cafés are useful for generating ideas, sharing knowledge, stimulating deep thought and exploring future ways of working (Brown and Isaacs, 2002). The collection of data through the workshops revealed insights into the history of partnership-working between the 'resident' and 'professional' community, as well as providing a forum for local residents to engage in active dialogue with the professional community.

The data from the semi-structured interviews and the action research event was transcribed and thematically analysed in NVivo.

Photograph 1: New Housing Development

Photograph 2: Terraced housing undergoing renewal

Photographs 1 and 2 juxtapose 'new' and 'old' housing within the East Manchester area. Interviews from local residents indicated that the housing represented in photograph 2 evoked feelings of belonging, attachment and social meaning. Photograph 1 represents 'new build' housing which aesthetically looks more pleasing, but did not incorporate the components of place attachment, being seen by local residents as devoid of atmosphere, community character and social intimacy which was fundamental to their well-being.

Local residents felt that these aspects of well-being were being impacted upon as a result of the regeneration, where physical transformation fractured their social valuation of the community and their sense of place. Improvements to the quality of the local environment are vital to alleviating the problems which compound the most disadvantaged areas. Yet initiatives to improve the public realm thus far are not considered comprehensive enough to

deliver the combination of outcomes that are necessary for comprehensive regeneration (Scottish Executive, 2006). The experiences of local residents outlined above suggest that the regeneration can have overwhelming impacts on the local community, where changes to the physical infrastructure and design of a place, can sever social ties, and influence local resident's sense of belonging and identity. Interviewees felt that the community had significantly changed in east Manchester; places that had functioned formerly as community hubs had since deteriorated and been closed down yet not replaced by other amenities or facilities with the same sense of place attachment:

"We have always used lots of shops… you could go in and have a cup of tea with the guy who owned the newsagents…We have lived here all our lives, there have been shops all the way down. Now everything has gone."

"That church coming down has nearly seen me off… that was the most important thing in my life… it was the only thing we had where we could all gather together."

"Now they are pulling things down and the precinct is going so there is even less... it was a place for people to meet…it is not intentional that you go to meet people… but if its not there then you are not going to meet them are you?"

Well-being defined from a review of the academic literature included individual, social and community perspectives, whereby the need for personal development and human flourishing (eudemonic factors) is closely related to happiness and enjoyment (hedonic factors). Well-being is also viewed through academic literature as a process rather than a state of being, including personal growth, achievement and flow. Academically based concepts of flow and individual achievement were not evident in the experiences of local residents who prioritised community and social networking, whilst the

regeneration perspective focussed less on well-being per se and more on the attainment of objective key performance targets concerning housing, educational and employment opportunity.

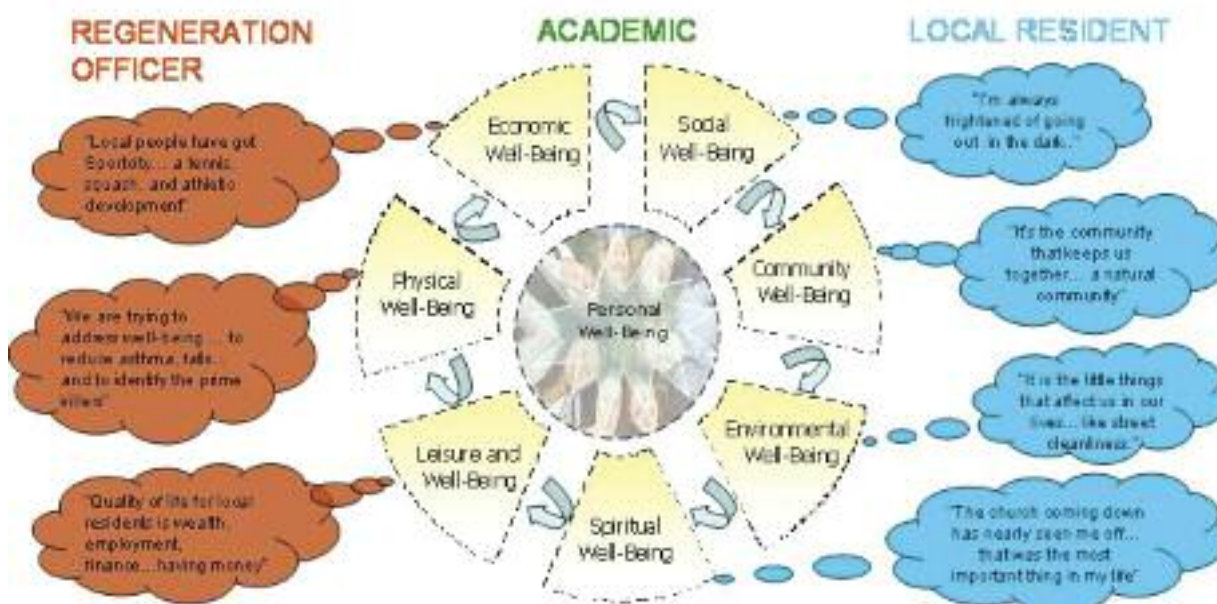These differing perspectives are represented in figure 1 below.

Figure 1: Conceptualisations of well-being

6.2 Consultation, Engagement and Ownership

The local Regeneration Framework for the area identified the importance of community capacity building, with an emphasis on 'strengthening communities' and the need to ensure that local people have the *"skills, knowledge and abilities to effectively engage in their area" where "the key to ensuring that community facilities continue to meet demand of the local communities is to encourage community ownership"* (New East Manchester, 2001, p.57). Despite this being highlighted as an achievable goal, regeneration professionals revealed that previous attempts at participation had rarely developed into community ownership, capacity-building and long-term engagement. Findings from the research indicated that there was no common protocol amongst regeneration professionals for defining what constitutes effective engagement nor were there any evaluation mechanisms to ensure that it happened. As a result there was little consensus across regeneration professionals about what participation and engagement is for and to what extent it should operate;

"Effective community engagement is difficult to achieve. We have often consulted with the local community without really thinking about why it needs to be done and how we are going to do it. I am not sure that there is a right answer."

"We have tried getting the participation of local people but they still report that we have not involved them. It's difficult to reach everybody when note everybody want to be engaged."

Regeneration professionals and service providers identified that effective partnership-working need to ensure that local residents are central to the decision-making process through the design and implementation of community places in the regeneration:

"It is important to consult local people in the design of community spaces. Whilst time consuming and expensive it gives people a higher sense of ownership over the place that they are in. It will translate into better use of that space and a better sense of well-being."

Regeneration professionals and service providers identified the importance of accessing the knowledge of the local community illuminating the integral role of the regeneration in promoting the effective empowerment of local people. The advent of Health Trainers in the local community is a step in the right direction to achieving this (DoH, 2004) the success of which has led to the recruitment of local people in the area of East Manchester (Devine et al, 2007). Regeneration professionals and interviewees identified the importance of utilising the skills and knowledge of local people:

"We need to empower disadvantaged communities to aspire to good health. Local people are in a better position because they have local knowledge and they are familiar with the local community. We need to makes sure that we work with them to encourage that after the regeneration ends."

Furthermore, the evaluation of regeneration initiatives and services in East Manchester have, unsurprisingly, revealed that local community involvement in the decision-making process increases the success and sustainability of that regeneration

initiatives in the long-term (Quaternion, 2004). The transferral of ownership of community spaces from the 'professionals' to 'local residents' increases the chance of that space becoming a well-used, well-maintained community place. The following regeneration professional identified the importance of including local people in the design and ownership of community spaces:

"The Community Gardens is about getting members of the community, local residents, to makes use of previously disused space. Our findings indicate that working together with local residents helps local people achieve their aspirations of what they want their community to be. It draws people out of their homes and get people socially interacting."

"Those spaces that are owned by local residents are almost entirely self-sustainable. They are pleasant places, are better used and work really well. If they are resident led they require less support from us and are better protected in the long-term. Those spaces which are owned by the local community are more successful than those that are not."

Evidence suggests that partnership-working which emphasises community participation and community ownership has positive effects on the health and well-being of communities as participants develop a sense of life purpose, autonomy and fulfilment (Brock, 1999; Narayan, 2000). The need for effective partnership-working between regeneration professionals and local residents is now becoming more critical as the regeneration in East Manchester enters a period of sustainability. The subject of 'community ownership' is integral to the sustainable communities agenda

(ODPM, 2005) and 'community empowerment' is seen as a priority area through the creation of stronger, more prosperous communities (CLG, 2006).

Local residents felt that the history of consultation and engagement throughout the regeneration had failed to meet their expectations leaving them feeling disillusioned and disenchanted with the regeneration process. They felt that 'mild' forms of consultation, such as 'being invited to a meeting, a local event or to complete a survey' were not effective forms of engagement as they often failed to engage them in the decision-making process. Residents experiences of consultation which failed to meet their expectations or raised false expectations had a negative impact on resident's well-being and discouraged further engagement in future consultations. Residents thought that knowledge-sharing, reciprocal dialogue and active listening were all important aspects of any engagement process, but were absent from their experiences. Importantly, local residents felt that actual change as a result of the consultation process was not instigated by those responsible, leading to feelings of frustration and subsequent alienation and disengagement.

Whilst a diverse range of consultation techniques have been undertaken, interviewees identified the negative impacts that can arise when taking part in consultation. The comments suggested that further work can be done to improve the level of information and awareness of local residents about their expectations from the consultation process by addressing more closely what participation is for and to what extent it should operate (Dinham, 2006). The following residents indicated that

all consultation within the regeneration must be seen as a worthwhile exercise to local residents, a process which keeps them engaged and informed about how the consultation will ensure their long-term engagement. Local residents indicated that there was a significant difference between information 'sharing' which gave local residents the opportunity to have open dialogue and having professionals 'telling' them which was seen as one-way communication. Moreover, they needed to see change as a result of consultation with professionals and if this failed to happen, they became disengaged. Local residents stressed the importance of being kept fully informed in the consultation process, receiving information which was clear and appropriately communicated by professionals:

"They just fob us off. They don't tell us anything. I think they must think that we're stupid or daft. Its just ticking boxes for the regeneration team. They just sit there and tell us what is good for us."

"I can't think of one time that we have been involved as part of the consultation where they have taken on board what we say and gone and done something about it. It's just not happened."

"The regeneration are not listening to what we say. They come in, tell us one thing and then do another. We sent them a letter detailing our complaints. We know where that is. Its in the bin. I don't think there listening to people today."

"We need to be told what is going to happen and when. Why is it all so confusing to find out what is happening. Its all been decided upon without any knowledge from us."

Whilst consultation is one aspect of community engagement identified in the city-wide toolkit, there are many other elements to community engagement which are equally important including: continuous involvement, supporting community action; and devolved decision-making (MCC, 2005). The following comments suggests that effective engagement should involve the continuous involvement of local residents, tapping into the local knowledge of residents, and ensuring that their expectations are managed throughout the process. Being more informed and aware of consultation and engagement process possibilities i.e. through the fulfilment of expectations can ensure that local communities feel more involved and included in their communiry (Dinham, 2006). This process needs to be balanced sensitively as engagement with local residents is a complex process, which is not always beneficial as there can be difficulties when translating the theory of community engagement into practice (Wilcox, 1994). Consultation which is inhibitive and not conducted effectively can lead to feelings of frustration amongst local residents. Local residents need to be engaged in a process of active listening and shared dialogue which is both participative and empowering:

"They don't know what it means to live in this area. They just think that we are do-gooders. If they could put themselves in our shoes then they would realise."

"The consultation that I have been part of has been patronising. They talk to you as if you don't know what you are talking about. They don't actively listen to what you are saying. "

"It [consultation] means absolutely nothing. I came out of the consultation feeling flat as if it had made no difference whatsoever."

The literature on community engagement and consultation has a long history and has been strongly influenced by Arnstein's (1969) ladder of participation. The ladder of participation suggests that true engagement can only be achieved when there is effective partnership-working that encourages delegated power [to local residents] and where there is a sense of [local] control over the design and management of regeneration programmes. The experience of local residents suggests that attempts at consultation have failed across a number of these themes: there has been a lack of information and awareness about regeneration programmes in the area; consultation has failed to incorporate residents views into regeneration change, and that previous highly controlled attempts at 'partnership-working' had dampened local residents enthusiasm to be engaged in the future.

The experiences of local residents suggested that effective partnership-working, delegated control at the community-level and citizen control were still absent from regeneration participatory practice. Indeed, the research found little evidence to suggest that planning and decision-making responsibilities were being shared between regeneration professionals and local residents. As a result, regeneration initiatives have emerged which do not include the local community in their design and implementation. In many cases this has impacted negatively on the well-being of local residents, as it has threatened concepts of community identity, familiarity and belonging through regeneration which fails to incorporate the tacit knowledge of local residents.

6.3 Informal Health and Well-being Providers

Resident disengagement from the regeneration can bring about feelings of disillusionment and disenchantment. These feelings can have negative impacts on communities who respond to such adversity in one of either two ways. The first response is for residents to become increasingly disenchanted and disillusioned with their community and the surrounding area. As a result, communities can become inward-looking and divided as residents are less inclined to get involved in civic life which has deleterious effects on social capital. This impact on communities has been described by the social commentator Robert Putnam as a symbol of individuals 'hunkering down' (Putnam, 1999) where communities become introverted as a result of what they perceive to be social injustice as described by the following residents:

"People around here have turned in on themselves a lot more. Nobody wants to challenge anyone these days. They think they can't do anything. They don't want to go out of their front doors."

"The community used to be a lot more responsive. Now people just operate within their own homes. You don't get the active neighbour anymore. Those people that would knock on your door when times are bad."

"Everybody used to come out and do their bit for the community. But now, people are more isolated and not as many people bother. I don't think people feel that they can change things as much the used to."

The second response from communities who feel marginalized or excluded can be described as one of solidarity and collective effort, where residents develop strong social ties in times of adversity. This second response was typical of many living in the deprived communities in east Manchester and was described by the following interviewees who were members of 'communities of resilience'. Left to effect change themselves, they had developed stronger, more cohesive communities in challenging regeneration initiatives:

"If we didn't do it, nothing would get done at all."

"The community needs to be strong when times are tough. People get sick of all the crime and things. The gangs are the ones that come in and cause all the problems. We were sick of them causing problems in our community. That is why there is still a community round here."

"They don't do anything for us round 'ere unless they are fighting all the time."

"We keep it nice round this area. We now that nobody will help us. It wouldn't be so bad if they said we are looking into it but we never hear another thing. They are not going to do it so its left to [residents names] and myself. We work together and we get things done."

This data supports findings from other research conducted in disadvantaged areas where, in times of need, communities develop relationships based on principles of social justice which can be beneficial to health of both the community and the individual (see Campbell et al, 1999). The importance of social ties in deprived areas has been previously identified whereby *"the poor neighbourhood may have weak and inward looking networks, which nevertheless offer strong support in adversity"* (Kagan et al, 2000, p.2). n

an effort to grasp some ownership of regeneration in the area, informal types of engagement had emerged as common practice amongst the deprived communities in the regeneration area. Formally disengaged and disenfranchised members of the local community developed informal methods of engagement such as generating neighbourhood campaigns and community gardens. These methods of informal working were bound together by public characters within the local community who were seen as informal community well-being providers, active in encouraging participation and engagement of other neighbours and community members. The availability and quality of these groups were integral to the development of social capital across communities within the regeneration area.

"It is one person on a street that does everything and takes responsibility. It has been like that for years."

"People like [residents names] give us a place to go if there is a problem. If you need anything then you can go round there. You know that if you are frightened or anything like that then you can go round there."

"If he is going to the precinct they he will ask us if we want a bit of shopping, I'll give him some money and he will go and get it for me. If I need a prescription, I will fill in the back and he will say right I will go and get it for you and bring it back.

"It's nice that [resident name] is looking out for you because sometimes you can feel a bit on your own."

"If I tell [resident name] that I am going in hospital for a fortnight or a week then she says right I will keep an eye out on your flat. I have known her since I moved in here. I'd be knackered without her."

These local characters were active in addressing problems within the community and improving the well-being of other residents by providing emotional support for local residents and encouraging the participation of other community members in issues which directly affected their lives. Moreover, these active members of the community, seen as 'informal well-being providers', variously experienced emotional highs (when achievements were made) and those residents who actively participated experienced improved well-being through raised self-esteem, positive affect and personal fulfilment. Although these informal networks represented a valuable resource to local communities, they typically fall outside of the formal partnership-working taking place through regeneration practice. As a result there was no formal support for the informal well-being providers whose attempts at garnering participation and problem-solving in the local community had deleterious effects on their health and well-being through mental stress and physical burn-out. Resident interviewees identified the negative impacts of active participation especially in the regeneration experienced on a daily basis.

"It gets on top of you. A lot is expected of you. You are fighting on two fronts. The needs and wants of local residents and then battling with the professionals and the service providers. It gets a bit on top of me and I have got bags of patience."

"Sometimes you take on the problems of the whole community and it can weigh you down. If there are problems and issues in the community then it affects my whole mood. If things are going well, I feel great. If they are not going so well, I don't feel so great."

"There are times when you say enough is enough. You get burnt-out. That's when I have to take a couple of days off. I go and see my family for a couple of times. Then I can reflect, recuperate, come back and take it all on again."

"We are stressed. We don't have an outlet. We are never away from it. You cannot just walk away from people with problems and say 'You'll be alright'. They have got no-one else. "

Informal health and well-being providers are integral to active community involvement in the consultation process. However, they would require the necessary support and the resources at the community-level to facilitate this (including: financial resources; emotional support; and established trust and reciprocity with service providers) as such activity can be psychologically stressful (Raschini et al, 2006; Sixsmith and Boneham, 2004). Effective partnership-working with the local community has been shown as essential to the success of regeneration initiatives aimed at improving the health and well-being of local residents (Scottish Executive, 2006). Evidence of partnership-working reveals that community representatives engaged in partnership with the regeneration agency can have a positive impact on the success of regeneration initiatives (Purdue, 2001).

However, further work needs to be done to manage the expectations of the local community in the planning, design and implementation of place-specific regeneration programmes which can help deliver effective and lasting regeneration (ODPM, 2005).

These attempts at engaging with local residents are identified in the city-wide engagement toolkit (MCC, 2005) but effective consultation and engagement as part of the regeneration needs to enable knowledge sharing, active dialogue and shared decision-making with local residents. Furthermore, they should sensitively manage and support the health and well-being needs of community champions or informal health providers who typically suffer stress and burn-out as a result of actively participating in their local community. This needs to compliment the work undertaken and by the New Deal for Communities resident liaison team, which has been active in engaging and developing relationships with residents liaison team members/tenants associations.

The action research event organised within the research project highlighted the willingness of regeneration professionals and service providers to work more effectively to engage with these members of the community (see photographs 3 and 4 below). This constituted a proactive effort to reconcile the sorts of informal participation described above with the formal processes of participation previously undertaken.

6. Findings

The findings revealed that there were a number of inter-linked factors which influenced the perceived success of partnership-working between the 'resident' and 'professional' community. These thematic indicators were crucial to understanding the objectives, processes and achievements of the collaborative partnership between the local residents and regeneration professionals. The findings from the project identified the partnership as a complex reciprocal process between the 'resident' and 'professional' community governed by a number of factors including: differing discourses on health, well-being, participation and engagement; history of working together; existing decision-making structures; information, awareness and communication; trust, reciprocity and ownership.

6.1 Differing Discourses on Health and Well-being

When understanding the notions of health and well-being within the context of regeneration it was necessary to ascertain how the concepts of 'health' and "well-being' might differ in their interpretation between regeneration professionals and local residents. This interpretation is crucial to the ways in which regeneration is addressing the concepts of health and well-being in the lives of local residents. Regeneration professionals articulated the concept of well-being through the achievement of measurable targets and outcomes defined as key parameters in the regeneration evaluation. These targets were defined as both health indicators (life expectancy, infant mortality rates) and wider health determinants (such as educational attainment, housing conditions, crime rates and

employment indices) through which regeneration professionals hoped that well-being would derive.

"We will only improve people's well-being if we narrow that gap between East Manchester and the rest of the city. It's about health inequalities."

"We are focussed on the economic side… employment gives people money… and this naturally lead to better well-being and quality of life."

"The housing market renewal process has been a fundamental part of the regeneration. Build more houses, attract people into the area and new business. That is what is going to sustain the regeneration in the long-term."

The experiences of local residents indicated that well-being was located firmly within their social and community life. Local residents identified a number of factors which they perceived as important to their well-being including: their sense of place attachment; feelings of community identity; their ability to develop and maintain social relationship; and their ownership of and engagement in community places. Residents felt that having access to strong social ties and networks of emotional support were important to the development of their sense of well-being. These strong ties were defined in terms of relationships with their immediate neighbours and other residents in the local area:

"What's important to me is being surrounded by people that I know, friendly people. If you have your neighbours, then the problems around 'ere don't seem half as bad. And the good times better."

"That social stuff is important in my life. It is that neighbourliness. It is about one neighbour going over to another neighbour when they are poorly and saying 'Look, I'm going to the shops, do you want me to pick up some shopping for you?"

Local residents identified the importance of community 'hubs' as places for creating, maintaining and accessing social capital. Here, local residents identified a strong environmental component in building social capital. Importantly, residents felt that such places were central to the creation of cohesive communities, as they brought different sections of the community together in a common place which allowed mutual understandings to grow and community norms to be transmitted:

"If you're working all week, how do you get to meet people? The market can be great for that. It's a meeting place. A place to go and see everyone. Absolutely fantastic."

"It [community places] is a way for everybody to get to see each other. They bring the community together. Then everybody looks out for each other. These places bring everyone together."

"It's a place for people to go and chat. A place for people to interact and communicate. That is just what you want in your community."

"Its important to have a place to go to where you can mingle with other residents in the community. A place where you can learn anything about the community that you need to learn."

They recognised that the poor history of working relationships and the established power imbalances need to be re-dressed before the required trust and reciprocity could be generated. Once harmonious joint working with informal community well-being providers was established, the capacity of local people to participate and to remain engaged after the regeneration funding ceases could be enhanced. Importantly, the inclusion of informal well-being providers represents an opportunity to shift power dynamics to be more reflective of the experiences of the communities being regenerated.

Whilst informal well-being providers represent a model to advance the participation agenda in regenerated communities, more work needs to be done to ensure that future consultation and engagement is designed around the needs of local people. Local residents need to be seen as equal in the decision-making process where informal well-being providers are legitimised as representatives of the local community.

For this to take place, there needs to be more work with local communities through informal modes of engagement aimed specifically at relationship-building at the community level. Informal engagement and the networks that develop within them need to be integrated into the existing partnership model. Failure to engage with these networks will result in local residents feeling that the attempts of the regeneration to develop truly effective partnerships are both disempowering and disingenuous.

Photographs 3 and 4: Knowledge café workshops bringing together residents, professionals and academics.

7. Conclusion

Regeneration policy has increasingly dictated an integrated and holistic approach to alleviating problems in inner city areas. This policy has identified the importance of engaging in collaboration with the local community through partnership-working towards a shared regeneration vision where regeneration initiatives are shaped around the priorities of local residents. That partnership between regeneration professionals and local residents was founded upon the need for a 'collaborative model' based on information and awareness, consultation, engagement through to shared decision-making and community ownership. It was intended that this facilitate physical transformation which addresses the social and community well-being needs of local residents (Mitchell and Shortell, 2000). The need to engage, empower and encourage the participation of the local community has been pushed from central government i.e. externally, the partnership can be seen as a policy instrument, which internally (i.e. through the working practices of 'professionals' and the 'lived experiences' of local residents) is resource-intensive and does not reconcile with existing engagement structures and resident liaison frameworks.. As a result, the research revealed that the form of 'partnership' which has developed between the 'professional' and 'resident' community has been fraught with power imbalances, different discourses and existing structures which have prevented a 'successful' or 'good enough' partnership from being developed between the resident and professional community .

The notion of well-being is a construct through which we can understand the experiences of people and places within the context of regeneration, physical transformation and social change. Closely allied to the concept of well-being is the notion of participation, and forms of resident engagement and partnership-working which are seen (through regeneration policy) as central to the long-term sustainability of regeneration programmes. However, the way in which the two concepts are articulated through the implementation and evaluation of regeneration practice differs from the experiential reality of local residents. There needs to exist the opportunities and pathways for shared knowledge, experiences and learning between regeneration professionals and local residents to develop shared visions about how improved health and well-being can be achieved through collaboration and partnership-working. Resident notions of health and well-being within community places need to be incorporated into specific urban planning policy, to ensure that regeneration practice creates community places which are socially and psychological meaningful. This will help towards the creation of community hubs which help generate health and well-being and importantly in creating sustainable communities in the long-term. From the outset New East Manchester aimed to create these places for the community through 'community hubs' (New East Manchester, 2001), the concept of which was given renewed emphasis in the latest Strategic Regeneration Framework for the area (New East Manchester, 2008).

The raised expectations amongst local residents about what the regeneration will achieve leads to feelings of frustration, apathy and disenchantment within the communities being regenerated. Attempts at consultation and engagement have been less successful as the partnership between regeneration professionals and local residents have become fractured. These schisms arise as the participation and engagement practiced by regeneration professionals fails to reconcile with the needs of local residents which includes a desire for active listening, partnership-working and equal power in the regeneration process. The resilience of local communities has led to the emergence of informal networks of engagement in communities, driven by active members of the community to address local issues. Such informal well-being providers encourage the participation and engagement of other members of the community. Whilst this provides improved wellbeing through raised self-esteem, positive affect fulfilment for those engaging, a lack of available resources, training and communication channels has resulted in some experiences of stress and burnout. Current regeneration practice suggests that whilst informal yet active groupings remain outside of the formal engagement process, they will be excluded from the assistance afforded by formal partnerships.

If participation and engagement through regeneration policy and practice is to engage the local community in effective partnership-working and relationship-building then regeneration agencies and service providers need to work towards a shared vision and experience of what the notions of (i) well-being and (ii) participation are within the context of regeneration and partnership-working. Failure to engage and participate effectively is unlikely to sustain the interest and long-term support of local people. This can have detrimental impacts not only on physical and social community places but through engendering feelings of disillusionment and experiences of poor well-being within local residents. Local residents need to be seen as equal in the decision-making process where informal well-being providers are legitimised as representatives of the local community. For this to take place, there needs to be more work with local communities through informal modes of engagement aimed specifically at relationship-building with the community in their local area, in line with the current national policy trends toward community empowerment and capacity building (CLG, 2008). Informal well-being providers represent a model to advance the participation agenda in regenerated communities. Further work needs to be done to explore the capacity to support informal health and well-being providers within existing formal engagement structures.

An informal engagement agenda needs to compliment the existing formal engagement which is undertaken through current regeneration practice. Community involvement which is facilitated by informal providers within the community will be much reflective of the community and is more likely to be sustained in the long-term.

A key challenge of the regeneration is to re-build effective working relationships through partnerships that help 'bridge the divide' between the 'resident' and 'professional' community. This requires the development of an engagement framework which facilitates changes to existing decision-making processes, resource allocation and power relationships. This is a significant challenge – although the premise of community led regeneration was the grounding for the New Deal for Communities programme and later developments have seen established directives for effective participation through Local Strategic Partnerships. Whilst this directive has been established within current regeneration, the experiences of regeneration professionals and local residents operating outside of this system (that is the New Deal for Communities) suggest that, in practice, these changes are difficult to implement. Firstly, the unique attributes of communities prevent a 'one-size' fits all approach to addressing participation in deprived communities yet there is emphasis on having a framework for such engagement.

Secondly, the extent to which participation can be undertaken depends upon the resources allocated to regeneration professional engaged in that type of work. Thirdly, effective engagement with local residents requires creativity and imagination from regeneration 'professionals', of which there is limited opportunity for within some of the current funding systems. Fourthly, if capacity-building and power sharing are 'desirable' outcomes, will the 'professional' community be inclined to relinquish power and move from a formal partnership towards an informal, flexible approach where the outcome maybe unexpected; and where 'outputs and outcomes' are such an essential aspect of regeneration evaluation and funding.

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Notes

Chapter 5: Swimming in Both Waters: A Case Study of the Manchester Learning Disability Partnership

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Contents

Executive Summary

This case study formed part of a HEFCE funded project to examine the nature of partnership working. In particular it uses the Warnwarth Framework to examine the Manchester Learning Disability Partnership (MLDP). The intention of this report is to identify salient features of the development and organisation of MLDP that may be useful to new partnerships.

In-depth interviews were conducted with key members of (MLDP), the tape recorded interviews were transcribed and a thematic analysis of the transcripts was undertaken.

Both Management Team and Partnership Board meeting minutes were examined. This enabled the communication processes operating within MLDP to be outlined. Key aspects of MLDP's communication process are: the open exchange of information, the production of detailed minutes and dissemination of information.

Features are identified which account for the sustainability and longevity of the partnership over a period of 14 years. The nature of inter-organisational and inter-professional working within the context of the partnership is examined.

Introduction

Although there is extensive literature on partnership working, especially in the realm of health and social care, much of it can be characterised as offering a 'pessimistic model' (Hudson 2002) . Typically, differences in organisational culture between health and social care institutions and/or difficulties in inter-professional working are identified as 'barriers' to 'successful' partnership working. Hudson (2002: 15) notes '…*there is also support for the possibility of a more optimistic view of inter-professionality. Even though harmonious relationships may be only patchy and partial, the fact that they do exist suggest that it is time to move on from an unduly pessimistic view'.*

This case study is offered as a counter balance to this 'pessimistic view': the Manchester Learning Disability Partnership (MLDP) has been in existence since 1999. Prior to this a Joint Learning Disability Service, in which some of the people currently working in MLDP were employed, operated from 1994 (MLDP, 2008) Some of the participants in this piece of research have been key players in the partnership since that time. Internal organisational documents, together with oral histories of key individuals who have been closely involved in the establishment and continuing development of the partnership provide the materials from which this case study is constructed.

A consequence of the NHS & Community Care Act (1990) was that professions had to learn to work together in pursuit of their goals. This departure from previous models of working was significant and characterised by the development of partnerships. This makes it an interesting and relevant case study because it is possible to trace the

development of partnership working over an extended period of time and to understand the elements that have contributed to the maintenance of the partnership.

There are a range of government reports which promote the integration of services and joint working between health and social services departments. (DoH 1997), (DoH 1997a), (DoH 1998), (DoH 1998a), (DoH 1998b) Reference is made in the interviews and the texts of the period that were authored by members of the management team to the policy drivers that shaped the work being undertaken.

Better services for vulnerable people (DoH 1997) laid down the requirement for a JIP (Joint Investment Plan). The development of the JIP is described clearly within the partnership board meetings of MLDP.

It will be shown how the sustainability of this partnership has rested upon both matters of inter-organisational working and inter-professional relationships. Initially, the purpose and workings of MLDP will be described. Then the establishment and development of MLDP will be located in the policy context. Inter-organisational working will be examined in terms of senior organisational 'sponsors' and financial/operational matters. The ways in which individuals may 'use' differences in organisational ways of working to achieve their purpose links with inter-professional working. Exploration of such matters displays the crucial nature of being 'innovative'.

How this case study fits into the overall HEFCE project

This study is one of five case studies that are intended to provide information that will inform the development of a best practice evaluation framework for the assessment of partnership working in the context of health and well-being of communities.

Methodology

Thematic interviews were conducted with key members of the organisation using a free ranging interview with a series of guide questions to initiate conversation. Each interview was markedly different from the interviews of other interviewees, the rich detail presented in each of the transcripts is illustrative of the nature of service operation at the time which was both innovative and risk laden.

Some of the key figures within the organisation have been a part of the MLDP, and its pre-cursor the joint service, from its beginnings. This has contributed significantly to the success of the organisation. The longevity of the relationships and the familiarity of each member with the management team has facilitated a productive working partnership.

Oral histories are useful tools in the understanding of learning disability nursing and Mitchell & Rafferty (2005) note that there are various accounts both from people with learning disabilities and from the staff who supported them. This case study is in the latter category and concentrates on managers in the service.

As is not unusual when using an oral history approach, there was little need for a comprehensive interview guide. Interviewee's accounts displayed the features that had contributed to the success of the partnership.

The interview guide questions were only loosely adhered to and respondents were given free reign to take the conversation where they thought it appropriate.

A range of documents were examined. These comprised Partnership Board meeting minutes from 1999, management team meeting minutes from 1994, various books and papers authored by members of the partnership team, consultation papers and information from the MLDP web-site.

Purpose

The Warnwarth conceptual framework posits eight elements that can be said to contribute to a 'good enough' partnership to enable the desired work to occur. The case of MLDP will be examined in the light of the proposed conceptual framework identifying its salience and noting where inter and intra-professional working is successful.

The eight elements of the Warnwarth Framework will be examined in relation to MLDP. These are as follows:

Right reasons. The setting conditions for the partnership had their origins in the broad cultural changes that were influencing services throughout the 1980s. The managers in the partnership had worked in a range of services that had particular ways of working.

The training of staff was not as widespread or as effective as it is today. This contributed to a dichotomy between those for whom the institutional style of service provision was an uncomfortable compromise and those who worked in the setting without necessarily questioning the moral and ethical issues implicit in the medical model of care. Mitchell & Rafferty (2005) describe nurses who declared a degree of discomfiture with their

previous professional lives and their participation in delivering care in this manner.

Individuals interviewed noted the sense of dissatisfaction people had with the style of care being offered and their belief that people were entitled to a far better quality of service.

High stakes. The stakes at the time were very high as the process of de-institutionalisation was not optional once the legislative drivers (see below) were in place. The accountability and responsibility for outcomes was as much a feature of the respective professional status of the participants as it was an enforced aspect of the emerging 'scheme of work'.

Right People. The members of MLDP and its precursor the Joint Learning Disability Service were, viewed through the lens of history, highly appropriate for the task at hand. They were empowered to act by the requirement to implement the NHS & Community Care Act, DoH (1990), policy development and the increasing appeal of the ideas underpinning the philosophy and service models of normalisation.

Normalisation is a conceptual term that has its origins in the work of Scandinavian services in the 1960s. The adoption of the concept by various countries inevitably resulted in the development of a range of interpretations of the original term.

In the United Kingdom John O'Brien developed an interpretation of normalisation that defined a series of operational service accomplishments. The term Social Role Valorisation (SRV) was utilised and became one of many acronyms to dominate the health & social care lexicon.

It could be argued that the adoption of concepts such as normalisation and SRV served to unify the aims and

objectives of organisations that were struggling to work collaboratively. To ally oneself with an emerging, internationally important service philosophy had considerable appeal and in this sense the partnership was in the right place at the right time.

The tenets of SRV were echoed in the basic axioms of the Model District Service NWRHA (1983) and an acceptance of, and core belief in, these fundamental ideas is repeatedly evident in the comments of interviewees.

Right Leadership. The leadership of MLDP has changed hands over time. There is little to suggest that MLDP required different styles of management in response to particular situations but the different leaders over the duration of the partnership do have demonstrably different approaches. A key aspect of the MLDP leadership is the long tenure of most of the members in a North-West care delivery/support setting.

These different approaches do not appear to have hampered the core business of MLDP. It could be argued that the presence of a long standing core membership of personnel, albeit in varying positions over 20 years, has contributed to a sense of stability. The key members were drawn from learning disability nursing, social work and psychology fields. Information from individual interviewees reveals the extent to which informal consultation/advice occurred between personnel from the different professions.

Strong, balanced relationships. Inter-organisational partnership relationships can be complex particularly if there are a number of different partners (Fairhurst 2008) as in the case of MLDP. The complexity, whilst potentially problematic, is also a rich source of ideas. Accounts from individual interviewees highlight considerable investment in the creativity and innovation of the

members. Ideas were encouraged and different ways of thinking were supported in order to facilitate progress.

The identification of organisational differences was an early achievement of the partnership. One interviewee describes the methods by which differences were addressed in order not so much to eliminate, as to work in tandem with, power differentials. This process was to the mutual advantage of both partner organisations. Taket & White (2000) refer to the pursuit of advantage and cite Huxham's (1996) work on searching for collaborative advantage.

Trust and respect. can be linked with right reasons and right people. The social and cultural setting conditions for the evolution of MLDP were significant. It could be argued that a concept of 'values in action' was a guiding principle.

According to Lewis et al (1995) : 'Positive change in the learning disability arena can be understood in relation to the emergence of alliances that cohere around key ideological positions' .. There was a strong focus through the 60s, 70s and 80s on the developing consensus that people's rights and opportunities were not being served. This is exemplified by the discussions about the principles of normalisation.

There are, however, other more pressing factors that drove the origins of normalisation and these had their roots in the emerging issue of the concept of rights. Human rights were increasingly the focus of debate during the early twentieth century and the post Second World War United Nations Declaration of Human Rights (1948) served as a launching point for subsequent human rights treaties that were recognised in international law.

The uncomfortable truth that people with learning disabilities were denied the rights that were being debated and enshrined in treaties and policy is perhaps brought into sharp focus by the reports of the inquiries into South Ockenden l that clearly showed considerable deficits in the standards of care being delivered.

As the authors of the conceptual framework assert, *'trust cannot be purchased, enforced and is unlikely to occur in the absence of a strong commitment to shared values'* (Warne & Howarth 2009:43) The accounts of the interviewees illustrate the high levels of commitment to a shared value base.

Good communication. The MLDP members were, and remain now, particularly adept at communication. There are a number of communication processes embedded within the culture of the organisation, principal amongst these is the cascade approach. In this system the service manager personally signed all briefings before they were distributed. The Warnwarth framework suggests that individuals need to be confident in messages being communicated and feel able to advance ideas and criticisms.

MLDP operates a culture of open information exchange although there are clear parameters around this with a recognition of, and will to issue, clear statements and direct action in pursuit of the continuing development of the service. Arguably this is imperative if an organisation is to avoid the developmental stalemate of endless consultation and indecision.

Harrison et al (2003:35) note that communication processes will change as relationships mature. They state that in the formative stages of a partnership assumptions about communication needs are not possible. Over a period of time an increasing knowledge and mutual

understanding of partners (the maturation process) will enable some assumptions about communication to be made. Analysis of meeting minutes and interview transcripts provides evidence of maturation; there is tacit understanding of ideas and concepts.

Communication is both effective and of a high quality. This is evidenced by a clear direction within the partnership. Partnership board meetings are always well attended, actions to be completed are allocated to a range of people which secures interest, participation and a developing knowledge-base amongst the partnership members. Within the management team meetings work is undertaken by the most appropriate person and actions are recorded, work is reviewed and outcomes are disseminated. This iterative process can thus be seen to be producing clear outcomes that are the result of a coherent communication system.

Formalisation. The MLDP formalised the process of work at an early stage and had clear reporting structures. The principal protagonists in these new arrangements were social services and health staff who were co-operating to a degree not previously seen. Currently the partnership reports to parent organisations such as the Primary Care Trust, Social Services and the Strategic Health Authority.

Issues of authority, accountability, confidentiality and responsibility are perhaps less problematic than they would be for a nascent organisation. The length of time over which the partnership has operated has enabled MLDP to refine its formal processes.

Policy Context

It is important to understand the range of policies that were providing a steer for the partnership at the time. As with all services the strategic direction and operational decisions arise from the prevailing policy imperatives.

Policy making can be conceptualised in terms of either a top-down approach or a bottom-up approach.

Arguably the Community Care Act (1990) was the first coherent attempt to create a way of working that was truly multi-disciplinary. The issues of ensuring an effective multi-disciplinary approach to delivering care has always been problematic and the Laming Report (2003) serves as a harsh reminder of the work yet to be done to achieve a seamless service.

Baker (2000) points out that a significant barrier to integrated service provision is the political boundary between social services and the NHS. The former is run by local government and the latter is run by central government. There is potential for dissonance if, for example, the local government is led by an opposition party which takes a differing view of priorities from the party in power at Downing Street.

The structure and organisation of the NHS has been subject to change since its beginning in 1948. This continual process of examining the structure and organisation is an important factor to be understood in the context of the development and maintenance of the partnership.

The NHS operates its own website www.sdo.nihr.ac.uk/ to guide managers through the complexities of the management of change. The emergence of the internet and its attendant proliferation of electronic documentation has arguably increased the knowledge base of health and social care managers.

This is a recent innovation, the pace of change was somewhat slower in the 1980s and the availability of such guidance, be it in the form of key texts or research papers, was relatively sparse. This was the case for MLDP, they came into operation at a time when information technology was not as advanced as it is currently.

The organisations in a partnership have a shared view of the principal need that informs the existence of the service being provided. However, the varying interpretations of 'need' as understood by different professional bodies have often resulted in tensions that have been difficult to surmount. This situation is reflected in a key point of debate within learning disability services (DH 1985;, Mitchell ,2003; Mitchell 2004; Northway et al, 2006; Clark & Diack2007)) namely that is there a requirement for learning disability nurses to provide services that could perhaps be provided by social care staff.

The origins of this debate can be traced back to the Jay Report (1979). The ensuing debates arising from it have never been satisfactorily concluded. There have been subsequent calls for a rationalisation of learning disability services that arguably contribute to a considerable degree of instability.

One of the key features in a successful partnership as elucidated by the Health Education Board for Scotland (1979) is the ability of different members of the partnership to offer "contrasting contributions to an agreed common goal" (Whitelaw & Wimbush, 1979:2). In this respect the, at times, diverse perspectives of health and social services seem ideally placed to fulfil this feature. Potentially problematic in this regard is the debate described previously within which a social care focus has assumed some degree of dominance.

There is a developing discourse about the 'loss' of a health focus in learning disabilities which has been initiated by a somewhat tardy recognition of the numerous health deficits experienced by people with a learning disability.(Turnbull 2004; Hardy et al 2006; Clark & Griffiths 2008)

The provision of community care services had to be tailored to local needs given the disparate nature of services around the country. Deeming (2004:57) notes that the NHS is considered to be over-centralised and local services may not always reflect the tone of government policy announcements. This is perhaps understandable when policy is generated from London, albeit in the wake of consultation, and an appreciation of regional nuance may be constrained. The MLDP management team were able to operate across local boundaries and were actively engaged with regional and national authorities.

An example of this cross-boundary working is given by Interviewee A in which he describes a conference that was held in Manchester:

The Secretary of State of the time was a guy called Stephen Dorrell and our response to that as a region, the then implementation team of the Regional Health Authority organised brilliantly a conference on what we were doing and why we were doing it and why it mattered and the way forward. We got Stephen Dorrell to speak at it and that was at the Britannia Hotel in Northenden that was a tremendous event and included a lot of people who had been successfully resettled from hospitals to come to that, to say however briefly, how it was. I remember Peter Clarke saying that one of the outcomes of that would be a form of words that said that the Northwest was committed to a range of options for people resettling from hospital

without stating what they were and if you were pressed you would point out that there were flats and there were houses and there were bungalows and all sorts of ways of supporting people in their own homes, short of saying hostels and continuing life for hospitals.

Kellaway and Ruane (1998) describe the biggest challenge as being how to start, what they refer to as the big bang approach (1998:103). They describe some of the many challenges facing the team at the time. One of the major problems was how to finance two essentially separate operations. This is a bridging matter, whereby the existing service (the existing hospital site and its services) needs to be maintained as well as develop the new resettlement scheme.

This financial double running required considerable financial investment and a great deal of negotiation in order to facilitate the process.

I guess we began working towards developing a joint service because we were getting a bit of a push from government at the time. There was a push to go for joint services and we began working together more and more closely. In the time we were doing it in 1994 (but really the build up to that the previous eight/ ten years I suppose from 1984), we had to work together to resettle people from the big institutions; from your (interviewer) old institution Cranage and Calderstones and Mary Dendy and all the other ones. I think wisely, the Northwest Regional Health Authority (NRHA) who had the money and the resources at the time were committed to partnership working. They believed that the local authority and health had to talk together before they'd agree to transfer the resources to the community so they had to work together. That was a big incentive really. That was one of the political

elements, I certainly think the fact that NRHA said that 'if you want the money that's attached to resettled people then you have to work together'.

A consequence dual funding identified by the managers of MLDP is that risks were inevitably taken because of under funding, particularly within the hospitals and the hostels.

The Audit Commission review of 1992 described the changing balance of care. At this early stage there was a recognition that costs were spiralling and as the report says the independent sector and voluntary agencies were "growing in significance". The Audit Commission review was entitled 'Managing the Cascade of Change'. There was a desire to, as the report says, "ensure value for people and value for money". (Audit Commission, 1992:1)

Community care was predicated on the notion that care for people with a learning disability, a vulnerable group in society, could be provided at a cheaper cost than institutional models of care.

There was a strong focus on the way services were commissioned and managed, and a requirement for a robust multi-disciplinary approach. One of the tenets of the Community Care Act (1990) was the development of a clear purchaser/provider split and for this to be effective services had to work collaboratively. It is important to recognise that at the end of the 80s a somewhat separatist culture predominated in which individual professional cultures had not yet homogenized to any degree.

The accounts of interviewees indicate that some services at the time of the NHS & Community Care Act (1990) assumed that the dowry monies were akin to a revenue budget which would continue. This was not in fact the case and members of MLDP had anticipated future changes in

funding. One of the interviewees describes the ability to 'horizon scan'.

The 1990 NHS & Community Care Act was seen as a way of addressing some of the difficulties with this multi-agency, multi-funded approach and a way to rationalise services. The Audit Commission review emphasises *"consultation and collaboration" with the opportunity for local services to be "restructured and re-orientated towards serving the real problems of people".* (Audit Commission 1992:1)

The process of implementation was considered to be potentially problematic because *"the process of implementation inevitably generates new difficulties which in turn trigger further adjustments in an ever-increasing cascade of change"* (Audit Commission 1992:1)

Authorities could be justified in feeling intimidated by the process but it is quite clear that MLDP did not in fact feel intimidated and responded to the various challenges that policy directives presented to them.

Manchester Learning Disability Partnership (MLDP)

Manchester Learning Disability Partnership evolved from the Manchester Joint Learning Disability Service. At the time of the publication of Valuing People (DoH, 2001) the learning disability population which was known to services was approximately 16,000 people. (see Table 1)

Provision	Numbers
Domiciliary care	155
Adult placement	50
24 hour supported accommodation	410
Support with less than 24 hours	43
Out of borough placements	26
Hospital beds for offenders	36
Respite care	167
Day care	397
Employment services	35
Care management	784

Table 1: The Learning Disability population

At the beginning of the partnership in 1994 a key issue was to develop integrated working practices. The Joint Investment Plan (JIP) was produced in the light of 1992 guidance on the development of health and social services for people with a learning disability. (HSG 1992: 42).

The JIP identified that Manchester's population was increasing from 430,000. This followed several years of population decrease that was most likely linked to a decline in local industries. Within the city 1200 learning disabled people at any one time received a service, with1500 people receiving a service over the course of a year.

Research undertaken in 2001 to support the development of the JIP indicated the need to increase provision by 15 % for people with severe disabilities and by 7% for people with less severe disabilities. This prediction was based over a 10 year period with an average 1% growth in demand each year. It was noted that there were 22% of children under 18 from ethnic minority communities mainly south Asian compared to 2.7% of the general population. Minutes from both the Partnership Board and the management team demonstrate that there was a clear focus on the need to address the particular issues of a minority ethnic population.

Wall and Owen (2002:75) describe organisational culture as a *"collection of ideas, values, norms and assumptions"*. This is seen as important because there will be an impact on the behaviour of participants within that particular organisation. Consistency and coherence are also described as important features, MLDP interviewees talk about notions of singing from the same song sheet and having the same set of core values and beliefs.

One interviewee commented on another interviewee's strong value base and described how he would disseminate and reaffirm those ideas through the various communication media used by the organisation.

Wall and Owen (2002) describe a range of changes which have affected health care and suggest that this has presented a particular dichotomy between professional culture, in terms of professional identity, and the actual practice of delivering community services. This has been clearly recognised by MLDP although not necessarily voiced in such terms.

Inter-organisational working

Kellaway and Ruane (1998:105) identify a minimum range of people who need to be involved in a partnership as a tripartite list:

1. People with a learning disability in their family

2. Staff

3. The community and its local representatives

It is evident from current and past MLDP minutes that individuals from each of these groups attend board meetings on a regular basis. MLDP tailor their ways of working for different audiences. The Partnership Board has a clear set of guidelines for people who are giving presentations. The target audience is identified as:

1. Self advocates, family members and carers

2. Councillors and senior health and social care staff

3. Representatives from partner organisations who may not have familiarity with learning disability services.

4. Representatives from charities

5. Representatives from the commissioning service and from providers.

Burton & Kagan (2000:3) describe what is known as the edge effect, a phenomenon whereby there is a notion of enrichment between different organisations *"when an edge is actually created we notice an increase in energy, excitement and commitment"*.

The interviewees describe the excitement and high energy that were present at the beginning of the partnership. Burton & Kagan (2000) identify that where people are working across traditional and

established organisational boundaries, the utilisation of the strategy of maximising the edge results in *"energy efficiency and a high likelihood of leading to sustainable and co-ordinated change."*

An interesting aspect of the development of the partnership was the co-location of nurses, allied health professionals and social services staff in the same base. This enabled joint working by dint of the fact that people were working alongside each other. The co-location of staff also removed physical barriers and the communication process was less constrained than it might have been if teams were dispersed.

One issue that was talked about was what one of the interviewees referred to as the "fear factor" in terms of professional identities. This is the assumption, however erroneous, that professional identity may be compromised by working in a joint service. This is a theme that is recurrent throughout learning disability services.

There was a drive to have integrated ways of working and one of the interviewees did comment that he had been waiting for a meeting one day and had been musing upon the fact that the service was so integrated that the respective professional identities, whilst not forgotten, had been displaced as an important issue.

He felt that people knew their professional identities but viewed themselves as part of an integrated whole. E-mail communications within the UK Health and Learning Disability Network bulletins provide indications of the continuing struggle of some services to achieve integration.

One of the interviewees talks about the breaking down of professional barriers in order to achieve an effective partnership and he saw that

as one of the key issues in the early days of the partnership. He felt that if staff were based in the same office with desks next to each other it was very difficult to maintain a sense of being separate. He described this removal of physical barriers as:

"… taking a quantum leap to actually basing people in the same office"

He felt that there was a great deal of dissatisfaction in terms of discrete professional identities. People were unclear about their priorities and co-locating staff in the same office helped to alleviate this issue. There was an encouragement from an early stage, actively supported by managers, in encouraging people to view themselves as a partnership rather than as members of their discrete professional organisations.

Burton & Kagan (2000) identify the need to respect the uniqueness of each community in a collaborative arrangement. The accounts of interviewees describe the respect for the unique qualities of each of the partner organisations; each organisation had a great deal to offer.

Interviewee A described the situation:

"Yeh. I think… I think you have to, you know…. when you're on the edge of two organisations for a long time at the Community Trust and the local authority… it was a good place to be in that we were our own masters and mistresses really and we could play a little bit off against the other. We'd say 'well the local authority are doing this' or we'd say' you know what the trust are doing, they're doing this, you know.' And we could bring the best of both to the other party and we could live on the edge of it. Of course it did… it could make you vulnerable if they were looking to get rid… to cut a whole service…

you could just cut us at the edge. So you had to get yourself well in nest with the other party so it was a …you wanted a degree of separateness but you also wanted to make sure you were meshed in because you couldn't afford to be completely separate".

Successful inter-organisational working rests upon the relationship between individuals, Meads and Ashcroft (2005) outline five preconditions for an effective relationship to develop:

Directness is seen as influencing the quality of the communication between partners within the relationship. Face to face communication facilitates a deeper understanding than that which could be achieved through telephone calls or written reports. Face to face contact allows for the non verbal information to be developed and this can create a better understanding. MLDP established co-location of staff at an early stage in the partnership.

Continuity of relationships is seen as important for the development of a rapport between individuals. Given that some of the people within the partnership have been working together for a number of years the .development of a rapport can be expected. The accounts of the interviewees illustrate the extent of the rapport between individual members of MLDP's management team. Individual respondents spoke with a degree of warmth that is indicative of a long standing relationship, for example Interviewee A said:

Right I can give you a couple of analogies around that, I said earlier on about one of the driving forces in terms of developing the partnership and moving us as far as we have done was (name of individual A) but a lot of the problems with him and

(name of individual B) is that they often conflicted quite a lot in terms of being very similar in wanting the degree of power and autonomy so (name of individual A) was fantastic but sometimes a little confrontational. What we have got with (name of individual A) is being a different perspective so we have had a change of lead in terms of the driving force. (name of individual C) is very different and where we have got a lot of strength in him is, his ability to be able to argue the point and where just for example, in some of the joint management teams especially the pooled budget which is the one where we get the greatest amount of pressure to either under-spend or break even, definitely not overspend, where in the past you could get to a situation in where it became heated, (name of individual A) would take his glasses off and be challenging. . (name of individual C)'s way of negotiating is a lot more different and a lot more subtle but no less effective so we have got different strengths from the different needs that we have had over the past and . (name of individual C) has really been able to build on the very positive.

Meads & Ashcroft (2005) consider multiplicity is the third pre-condition of an effective relationship. They suggest that mutual understanding of organisations will be greater if there is an appreciation of individual contributions. This is particularly relevant in the case of individual professional roles. If respective partners within the organisation are able to appreciate and understand the roles and functions of other people then it is felt that the relationship will be strengthened. This strength will support the management of relationships. The accounts of the interviewees give a strong indication of the degree to

which individual contributions were valued by other members of the team.

Parity is seen as the recognition that different parties within the partnership relationship need to have some notion of power within the relationship. If there isn't parity this will lead to a lack of participation and as such *"strategic objectives are not owned, may reduce morale and stifle innovation"*, (Meads & Ashcroft 2005:21) Interviewee accounts indicate that members of the management team of MLDP are comfortable with their respective positions in the partnership and participate fully in the strategic direction of the partnership.

Commonality is seen as the pursuit of a way of working together towards shared goals. If there is a common goal or objective there is more likelihood of the organisation working well, a shared culture will minimise the possibility of different understandings. MLDP was a new departure, it moved away from an identifiable social services or an identifiable health services trust and became a learning disability partnership and the shared culture emerged from that move to a new organisation.

In 1999 a series of regional seminars were conducted by the Health & Social Care Unit at the Department of Health to examine the nature of joint working between health and social services organisations. A number of themes emerged from the report. Relevant to this discussion is the organisational and policy context.

It was determined that there was added value from having a joint working approach to improving health. The possibility of widening the perspective of respective professional groups by working in a collaborative

way was identified. It is however worth noting that there were still potential conflicts in terms of organisations maintaining some degree of separation e.g. *"I have to convince my councillors that my PCG involvement is worthwhile"* (SS representative), (DoH 1999:6).

The interview accounts give examples of some of the complex negotiations between members of the management team and local and national politicians.

A time of innovation and a shared sense of social injustice

The period in which the NHS Act (1990) came into force was characterised by an emerging sense of social injustice. Learning Disability Services moved from institutional to community care in the wake of the 1990 Community Care Act. This move followed a number of pivotal pieces of legislation that arguably failed to achieve the required sea change in standards of care. A key example is 'Better Services for the Mentally Handicapped' DHSS,(1971) which outlined the need to address the very clear deficits in care, associated with an institutional system of care. In addition to the legal drivers there were increasing concerns resulting from a raising of awareness amongst the public about the standards of care in 'mental handicap' hospitals. Inquiries such as Normansfield (1979), Ely (1978) and South Ockenden (1978) also produced distressing accounts of institutional care and contributed to a growing sense of unease.

The screening of 'Silent Minority' in June 1981 on ITV was a catalyst for the production of the Green paper 'Care in the Community'.

Key texts from the period, Ryan & Thomas(1987) and Collins (1993) described the conditions in the hospitals and provided a rationale for change.

There were parallels with other services which were undergoing significant change. The Mental Health Nursing Review Team identified *"considerable advances in the re-provision of services against a background of growing public and media concern about people with mental illness in the community"* (DoH 1994:30)

MLDP gained recognition for the quality of the new service they had initiated, as Interviewee C explains:

Certainly when I… after it happened people kept…. you know, we won a prize in the health service journal mate, we were inundated with people wanting to come and talk to us and things and we ended up setting up a few days with various organisations [that] came and clearly we were one of the first ones bringing together such big services. It wasn't just that we were coming together but there was a single management model so that if you were local authority or health you managed the other side without a question but we had a shared vision and purpose. That we were running both soft services, field work services, community nursing, social work etc, as well as hard services in residential service and domiciliary and day care. Very few people were doing that and even now a lot of people have come together in joint services and what they've brought together is community learning disability teams. They haven't brought together community learning disability nurses with expertise in behavioural challenge and mental health and people with serious physical health

conditions, haven't brought them together with residential social work staff to work in long term support situations.

Another interviewee talks about having to spend a lot of energy in protecting the partnership through the various changes that occurred.

A significant change was the reorganisation of the three Manchester District Health Authorities (DHAs) and the development of community trusts. The initial Head of the Service does talk during his interview about the need to continually demonstrate value for money in terms of the organisation. He spoke of a premium for the provision of a quality service because of the development of mixed economies of care and the so called purchaser/provider split. There was significant pressure from private organisations/providers to tender for services. Therefore the PCT and social services partnership had to demonstrate that they were providing a good quality of care.

The issue of quality is a feature throughout the history of MLDP, as it is in all services, and work was done to address the challenges of providing a quality service. This included the production of a training resource, (Burton 1992).

A significant point which may explain the success and longevity of the partnership was their ability to operationalise policy in their own terms.

In the late 80s early 90s there was a clear imperative from Whitehall to run down/close the long stay institutions. MLDP made it very clear that they were going to prioritise the establishment of viable community based services in order to, as Interviewee D says:

"ensure that districts would be properly prepared to receive people from discharging hospitals".

He goes on to state that he was quite satisfied that, when people did come out from the long stay hospitals, they did go into a properly prepared community provision.

A comment made by Interviewee C was that:

"a key driver was in fact money in the guise of dowry monies which came attached to each person who was discharged from the hospital".

This money and its appropriate apportionment between different aspects of the service was, as he puts it,

"a source of quite a bit of tension and very healthy debate".

It is perhaps worth noting that at the time of the community care legislation being implemented there never appeared to be an understanding that the money would be a finite resource. It was received wisdom that the sale of the properties and the subsequent monies accrued would be more than enough to provide a very good level of service for the foreseeable future. With the benefit of hindsight, we now know that the monies did not in fact last forever. Currently learning disability provision faces a whole range of financing challenges. This remains an issue for all services to the present day.

"…but we know where we want to be and how we can get there but trying to do it within budgetary constraints is difficult no matter what political party…"

An interesting element of the financial problem was that there was an anticipation that people would die at the same rate and at the same age as they did within the hospitals. One of the many positive outcomes from

the discharge from hospital-based care was that people's quality of life improved significantly and with that their life expectancy. This has been reinforced by the increasing emphasis on health.

An important theme is that of people being, as was described by interviewee B, 'champions':

"A younger man was recruited; a real champion for this work and he drove stuff through the association of directors and social services."

It was felt this particular individual was able, with his communication skills and his commitment to learning disability, to drive things through particularly at regional meetings of Directors of Social Services. The nature of the move from hospital-based care to community provision was highly controversial at the time and proponents of the move faced considerable resistance. The presence of champions is seen as essential to the success of change, especially on such a large scale as that which was prompted by the NHS & Community Care Act (1990).

Interviewee A talks of political will, having support from central and local government, as being an essential ingredient of successful partnership working:

"you can't do it if a few politicians don't agree, so you have got to get them in your pocket"

In the early days of the partnership there was a degree of resistance from local people and some parents and they sought support from various places. In one instance a local MP initiated an adjournment motion that questioned the way in which the Regional Health Authority was proceeding with its resettlement. This meant that the partnership had to respond:

"You use strong rhetoric to promote what you are doing and you must expect people to exaggerate in the other direction"

He also describes notions of *"confidence and trust" between the people from different parent organisations and the need to have a shared value base.*

Interviewee D describes a 'ground breaking and innovative' management team. The team was ground-breaking in terms of setting up a multi-professional service and innovative in the ways that they managed the change from hospital-based to community-based care. There was a significant change management task to move from the models of care that were dominant, at the time, to a community based model which people were learning about as they developed the services. Pioneering work was being undertaken by Wolfensberger (1984) in terms of the process of normalisation or Social Role Valorisation and the idea that core values such as community presence and community participation were very important.

The MLDP worked hard in implementing the ideas and concepts of normalisation. An example of this is their assertion that they would not resettle anyone until the community placement was ready.

The team moved to a functional management system whereby each person had a defined area which was their responsibility. The team were able to maintain a general perspective through regular city-wide meetings to ensure that everybody was focused on the main objectives of the partnership.

One of the key questions asked of interviewees was whether they felt the partnership was effective. There was a unanimous view that the

partnership was effective and to a large extent this was considered to be because of, clarity of and agreement about, their purpose. This consensus contributed to the longevity of the partnership as there were no major disagreements about philosophy and service direction.

As mentioned in the Continuity section (P.18) the key members of the partnership had a long history of working, primarily within the North West region, so they had grown up together professionally. There was therefore a sense of familiarity and a sense of shared understanding.

Interestingly there were perceived differences in terms of drivers. One of the participants felt that at times he thought that other people would have liked him to be pushing harder towards the goal of effective partnership working and progress.

A key challenge in the early days of the partnership was the process of negotiation between the parents and families of people with a learning disability and the members of the MLDP.

When the concept of hospital resettlement was developed, following changes in policy direction, families were being told that their family members were coming home or coming back to the area. There was a lot of apprehension about this. One of the interviewees talked about an 80 year old lady being very upset about the thought that she was going to have to care for her, now middle aged, daughter after 20 years in the institution. In the light of this situation a key role of one of the interviewees was to negotiate with the families and explain to them how the process of re-settlement was to take place. Another interviewee described how MLDP liaised with families and helped them negotiate

their way through what may have seemed like quite daunting procedures.

The parents experienced various degrees of upset and may well have assumed that the process would impact on their lives quite negatively so the art of negotiating with parents and families was crucial to the success of the resettlement programme.

Many of the parents of people who were to be discharged from the hospitals had experienced the very negative and highly traumatic experiences of having their respective sons or daughters taken into care, sometimes under the auspices of the Mental Health Act (1959). Families had endured a very harsh experience and were faced with another potentially difficult time in having their children (now adult) resettled.

MLDP's ability to successfully liaise with families was very important and the continuing participation of parents on the Partnership Board, for example, is an indicator of the success of this process.

A great deal of work was done by senior members of the team to convince other staff of the value and potential for success of the partnership; the process of selling the concept of the service to staff members. A clear strength of the partnership was a commitment to 'the cause' amongst the participants. The cause in question was to facilitate a quality service for people who are arguably amongst the most vulnerable in society. The interviewees talked very positively and passionately about people with learning disabilities and about the need to provide a service that was of the very best possible quality. Respondents all had a broad range of experience within services and were able to bring this to

bear on their management of the partnership.

One of the members of the team was described by one of the interviewees as being very good at selling the commitment to the cause in the face of what was and arguably still remains limited financial recompense. His absolute commitment to the lives of people with learning disabilities came through in terms of the way he sold the service to people. Another interviewee comments on staff members remaining in the service for a number of years. This longevity of not only the senior management team, but also, more junior staff is an indicator of the success of MLDP.

Interviewees were asked if they actively sought specific types of people who are able to cross the traditional boundaries of different disciplines in order to work effectively in the partnership. One interviewee was clear that people become the people they are through working in particular environments. Interviewees felt that managers and staff were no different than other people but there was something about the situation that helped to develop the person. The support, training and development that people were given resulted in a staff team that was equipped to deliver the service.

Identification of opportunities

Burton & Kellaway (1998) describe the opportunities afforded by the emergence of a new joint service configuration. Policy formulation between agencies enabled the joint service to develop interagency work and to operate outside of the ways of working that were accepted at the time.

The ability to 'horizon scan' is an important aspect of the partnership and participants were able to cite examples of their clear vision of the way services should be. They were also able to develop this vision within the constraints of policy direction:

Interviewee C:

I think you needed to keep your eye on the ball at all times so a good example would be …not really politics but it's about policy…they brought out a vulnerable adults policy nationally in 2000, I think. We'd had a policy since 1996. They were consulting on this when …the woman who's an MP now but she was a law commissioner at the University….can't remember her name now….she was concerned…because I went and had a chat with her a few times…about this, about how we protect vulnerable people so we knew it was coming. The consultation as a joint service. We'd written a long response to the consultation document. We began a vulnerable adults policy four years before we had to. The local authority thought this was excellent and they were saying to us 'We must do this for mental health and elderly people too.' We never got around to it until government told them they had to. So if we were talking about horizons scanning, it's being aware of the shifts. Maybe a better example in terms of politics would be the shift around funding from where…I remember when we went from hostels and hospitals to network houses…we maximised people's benefits and we did not…we did not call them care homes. The reason we did not call them care homes was because it would have restricted how much money each individual person had. It would have meant all the charge fell on the local authority, it would have meant the houses would

have had to been compliant with care home legislation. It was normal. It wasn't ordinary. We were going for ordinary life and it wasn't ordinary life to live in a three bedroom house that was kitted out like an old peoples' home.

Interviewee A:

Right. Well the partnership that Manchester Learning Disability Partnership started in about whenever and prior to that I was chair of a regional health authority committee called the Mental Handicap Advisory group. This arose because in the very late seventies the then regional health authority was called the Manchester Regional Board, then it was called the North Western Regional Health Authority, which was the Northwest (except for Mersey) and it charged this group with coming up with a policy for community care in mental handicap, as it was called in those days. There had been a lot of movement nationally towards community mental handicap teams and greater inclusion of people with what we now call learning disability and so on.

A further example of this ability to think ahead was the ability to anticipate service directions. One example that is given is pre-empting the introduction of the LDAF training and getting staff in the service enrolled on NVQ courses. This was initiated several years ago in anticipation of there being an expectation that the workforce would need to be qualified.

The investment in training of staff did not just have the immediate benefits of a more competent and committed staff team but also the partnership forged, what have proved to be, enduring links with Manchester Metropolitan University and as one person put it:

"we were able to examine some of the stuff we hadn't examined before so we were able to embark on establishing a reasonable standard of research"

The partnership maintained a focus on was what they called 'maintaining the momentum':

'setting things up was the easy bit, it is about maintaining the momentum , about ensuring that things continue'

In order to keep people motivated he used a team brief which is not a particularly innovative concept nowadays; but this has custom and practice since 1994. An interesting aspect of the training and development of staff was one of the methods used to keep the emphasis on refining the quality of service. Money was used to send members of staff abroad to get a sense of what services were doing in different parts of the world.

Conclusion

The MLDP is a partnership that has existed over a fourteen year period and has evolved against a background of significant changes in policy. The partnership has been able to maintain its focus and continue to deliver a quality service to people with a learning disability in Manchester.

The multi-professional context in which key members of the partnership operated required considerable risk taking strategies and innovative ways of addressing problems.

The maintenance of relationships was achieved through continuing affirmation of the guiding principles and a demonstrable belief in the value of what they were trying to achieve.

The time of the early years of the partnership's existence was characterised by the need to challenge prior assumptions. The members of the team were willing and able to overcome barriers associated with organisational boundaries and develop innovative ways of working.

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Chapter 6: Case Study: Partnership Working in Therapeutic Services

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Contents

Introduction

The focus of this report is the partnership working of Therapeutic Services (an arm of the Big Life Group based within the Kath Locke Centre in Hulme, Manchester).

Aim

The aim was to explore partnership working from the perspective of Therapeutic Services.

The study uses the Warnwarth Conceptual Framework for Partnership Evaluation and the idea of the 'good enough partnership' (Warne and Howarth, 2009) to describe, unpick and evaluate the intricacies of working in partnership both between and within organisations. The context within which Therapeutic Services works is first described, highlighting the geographical area and business structure within which the Service operates.

Manchester

Manchester, located in the North West of England, is a densely populated city with around 39.1 people per hectare compared to 3.9 for England as a whole[1]. The 2001 consensus estimates a population under Manchester local authority of just under 400,000[2] but more recent estimates put that figure at over 450,000 equating it in population size to Liverpool (which has a similar density)[3]. By gender, under the 2001 consensus, approximately 49% of the population were male; 21% were under the age of sixteen and 13% aged 65 or over.

Manchester fares badly in terms of economic deprivation when compared both to the North West as a whole and to England.

As the table As 1 below illustratess economic activity and employment rates are lower whilst unemployment rates, the proportions of the population claiming a key benefit, job seekers and those on capacity benefits are higher[4].

Indicators of Economic Deprivation		Manchester	North West	England
Economic Activity Rate (Persons, Apr06-Mar07) [4][5][1]	%	69.9	76.6	78.6
Employment Rate (Persons, Apr06-Mar07) [4][5][1]	%	65.6	72.4	74.3
Unemployment Rate (Persons, Apr06-Mar07) [4][5][1]	%	7.1	5.5	5.5
All People of Working Age Claiming a Key Benefit (Persons, Aug05) [3][2][6]	%	23	18	14
Job Seekers (Persons, Aug05) [3][2][6]	%	3	2	2
Incapacity Benefits (Persons, Aug05) [3][2][6]	%	12	10	7

Table 1 : Indicators of Economic Deprivation
Taken from
http://www.neighbourhood.statistics.gov.uk/dissemination/LeadKeyFigures.do?a=3&b=276778&c=Manchester&d=13&e=4&g=351271&i=1001x1003x1004&m=0&r=1&s=1213876507695&enc=1

1 http://www.manchester.gov.uk/downloads/A22_2006MYE_Wards_Density.pdf
2 http://neighbourhood.statistics.gov.uk/dissemination/LeadKeyFigures.do?a=3&b=276778&c=manchester&d=13&e=16&g=351271&i=1001x1003x1004&m=0&r=1&s=1213881257390&enc=1
3 http://www.manchester.gov.uk/downloads/A22_2006MYE_Wards_Density.pdf
4 http://www.neighbourhood.statistics.gov.uk/dissemination/LeadKeyFigures.do?a=3&b=276778&c=Manchester&d=13&e=4&g=351271&i=1001x1003x1004&m=0&r=1&s=1213876507695&enc=1

Figures from the 2001 census also show Greater Manchester has a higher proportion of the population with limiting long term illness than the England and Wales average (20.4% and 18.2% respectively), a higher proportion of people permanently sick or disabled (7.8%, 5.5%), a higher proportion of people with no qualifications (32.7%, 29.1%) and a lower proportion of people with qualifications at degree level or higher (17%, 19.8%)[5].

It is important to note that even within these figures differences are apparent between wards. Within Manchester the average unemployment rate in April 2008 was estimated at 3.5%. However, in the affluent wards of Didsbury West and Didsbury East this is 1.3 and 1.4% respectively where as in Bradford the rate is 6.4%[6].

The focus of this report is the partnership working of Therapeutic Services based within the Kath Locke Centre. The Centre lies in the Manchester Ward of Hulme which borders the City centre, Ardwick and Moss Side.

In 1990 Hulme was given the dubious honour of being said by the government to have the worst housing estate in Europe. Since that time both Hulme and Moss Side have been undergoing extensive regeneration.

Indeed it's estimated that there has been over £400m of public and private investment in both wards since 1997[7]. Despite size and scale of the regeneration project, of the thirty two wards that make up Manchester local authority, Hulme, Moss Side and Ardwick have amongst the highest unemployment rates (4.6%, 5.7% and 5.2%)[8].

Indeed all three feature in the top 1% of most deprived locations in England using an index that takes into account income, employment, health and disability, education skills and training, crime, barriers to housing and services and living environment[9].

5 http://www.statistics.gov.uk/census2001/profiles/2A-A.asp
6 http://www.manchester.gov.uk/downloads/H1_Unemp_April_08.pdf
7 http://www.manchester.gov.uk/downloads/Hulme_10_years_on.pdf
8 http://www.manchester.gov.uk/downloads/H1_Unemp_April_08.pdf
9 http://www.manchester.gov.uk/downloads/F1_IMD04.pdf

Therapeutic Services

Therapeutic Services is situated nder the umbrella of Big Life Services, which itself is situated under the umbrella of The Big Life Group, a social enterprise. Recent estimates suggest there are over 55,000 social enterprises across the UK. Social enterprises account for 5% of all businesses with employees, have a combined turnover of £27bn and are estimated to contribute £8.4billion per year to the UK economy[10]. The Government, within its 2002 Strategy for Social Enterprise, defines a social enterprise as:

'…businesses with primarily social objectives whose surpluses are principally reinvested for that purpose in the business or community, rather than being driven by the need to maximise profit for shareholders and owners.' (DTI, 2002)
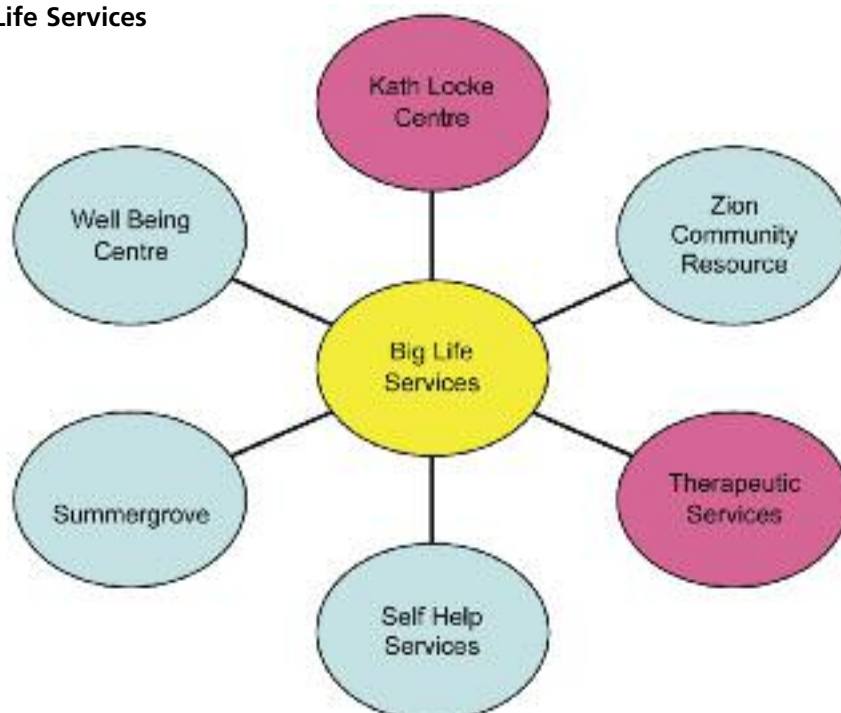
The Big Life Group consists of a group of social businesses and charities whose stated mission is:

'To bring about social justice for the most excluded in society -to create a new way of working and a new way of living. A world where people can make mistakes and be helped to move on and change. A world where everyone has the opportunity to improve themselves and develop their potential. Where people's needs are met, and their talents and assets utilised. Not a world divided into the needy and the sorted[11].

The Big Life Company, launched in 2002, came about as a merger of Big Issue in the North and Diverse Resources with roots going back over almost two decades (Diverse Resources was set up in 1991)[12]. It is based across the North West and in Yorkshire. Big Life Services, a limited company and registered charity within the Big Life Group, aims to identify

gaps in services and meet the needs of local people[13] by providing and promoting services to improve the health and well-being of people who have been excluded from mainstream society. Following a self-help and developmental approach, it focuses on the power of opportunity to change people's lives. Services currently offered include Self-help and Therapeutic Services across Manchester, Leeds and Liverpool and their surrounding areas. The services provided don't attempt to duplicate existing services but rather to identify gaps and work either alone or with local partners to meet local need[14]. Indeed they reiterate their belief in and support of partnership working.

The following diagram illustrates the structure of Big Life Services:

Structure of Big Life Services

10 http://www.socialenterprise.org.uk/page.aspx?SP=1345
11(http://www.thebiglifegroup.com/home/index.asp
12 http://www.socialenterprise.org.uk/Page.aspx?SP=1987
13 http://www.thebiglifegroup.com/charities/big_life_services.asp
14 http://www.thebiglifegroup.com/charities/big_life_services.asp

Big Life Services has, for over a decade, provided free and reduced fee access to selected complementary and alternative medicine (CAM) therapies in the Manchester area through their Therapeutic Services division. The services provided include counselling, homeopathy, Reiki and massage. The sessions are provided on a volunteer basis by trained and accredited practitioners. In addition a number of sessions are commissioned by the local Primary Care Trust (PCT).

Sessions are targeted towards persons at the margin of society either through homelessness, chronic long term unemployment or (mental) ill-health, or through their membership of particular minority ethnic groups.

Figures taken from the 2006/7 Big Life Group Annual Report[15] show the service received 306 referrals for counselling from GPs and undertook 1758 counselling sessions with 345 people over the period. Sessions were carried out at the Kath Locke Centre, Zion Community Resource centre and in GP's surgeries across the Manchester area. In the same period 64 people accessed complementary therapies (homeopathy, massage, reflexology and Reiki) with plans in place to expand these therapies at the Kath Locke Centre and that they are rolled out to other centres.

The Kath Locke Centre, managed by the Big Life Group, opened over a decade ago and is based in Hulme, Manchester.

The Centre was the first NHS primary care facility in England to be managed by the independent sector. The Centre provides or hosts primary care services that include chiropodists, dentists, audiologists and opticians. Services are provided by Big Life, the PCT, Local Authority, Mental Health Trust and the voluntary sector[16]. In line with the ethos of the Big Life Group the Centre offers a holistic health approach to well-being, offering traditional health care services alongside complementary therapies[17].

The services are available to the whole community giving everyone the opportunity to take control of their health[18].

Figures from the Big Life Group website report that over 32,000 people visited the centre last year.

15 http://www.thebiglifegroup.com/Uploads/230107biglifeannrpt0607.pdf
16 http://www.thebiglifegroup.com/Uploads/klc%20evaluation.pdf
17 http://www.thebiglifegroup.com/charities/kath_locke.asp
18 http://www.thebiglifegroup.com/charities/kath_locke.asp

Partnerships and Therapeutic Services: A Good Enough Partnership

Using the Warnwarth Conceptual Framework for Partnership Evaluation and the idea of the 'good enough partnership' (Warne and Howarth, 2009) this section of the report attempts to describe, unpick and evaluate the intricacies of working in partnership both between and within organisations. Focus lies on Therapeutic Services and their perceptions of partnership working; drawing on interviews with people working within the Service and documentary analysis.

Interviews were carried out with five people within therapeutic services in December 2007. Interviewees included service leaders and providers; paid workers and volunteers. The interviews were semi-structured; interview schedules (Appendix 1) and analysis were based on the initial Warnwarth Framework.

The documents included in the documentary analysis included Big Life Group annual reports and evaluation reports.

All documents were freely accessible from the relevant websites.

Therapeutic Services organisational partners come from both within and without the Big Life Group and include Big Life Services, the Kath Locke Centre, and the local PCT (who provide funding for the service). At the level of the individual, Therapeutic Services partners include those delivering the services and those referring to the service (for example, the mental health team or local GPs).

Partnership within Therapeutic Services

The Therapeutic Services team is made up of paid staff and volunteers, some of whom work full time, others part time.

Practitioners of CAM are often employed elsewhere in addition to their roles within Therapeutic Services. This means that for this group there are competing demands on their time. Turnover within the team has historically been low but this is set against the uncertainty associated with continued funding of the Service. During the research period there were a relatively high number of new practitioners but many existing practitioners had been with the Service for over two years.

This part of the report explores the partnership working within Therapeutic Services. Initially there were no plans to analyse this partnership, but rather to focus on the organisational partnerships at the level of the organisation and the individual.

However, when asked about partnership working, three of those interviewed initially assumed this related to the working within Therapeutic Services and focus of much of the interviews lay here. This led the authors to the assumption that, for these people, this partnership is the most important, most relevant, or at least the most visible within their working environment.

Many of the people working in Therapeutic Services come from within, or have roots in, the local community, and in this sense the partnership within Therapeutic Services includes partnership with local community. As one interviewee noted:

It's very much a partnership with the community and a sense that people are saying, this is something they want and we've found a way of helping them deliver it. And it's, you know, members of the community are delivering themselves in the sense that people are volunteering their time and are or are training and wanting the experience. And so it's people who are in the community and are helping to deliver the service that's very important. (5)

Another interviewee noted:

When we have events service users attend, we also have informal helpers who are service users that want to give something back to the community (1)

An important characteristic of CAM is the involvement of the service user in their treatment – of active participation in their treatment rather than of being 'done to'. Those interviewed talked about the partnership with the patient to the extent that the therapy requires engagement by the patient:

..you need them to feel part of the team that's healing them, no to be entirely passive in the process because it's their body's ability to heal itself that I'm trying to stimulate. I'm not trying to impose something that's wholly external to the body (3).

The culture in therapeutic services is about increasing clients self awareness, and getting them to help themselves,but being a guide and support at the same time (4).

Right Reasons

The Warnwarth framework suggests that there needs to be the right reasons for creating a partnership and that those reasons lie in a shared vision and collaborative partnership working. Interviewees had a shared vision for, and a shared understanding of the function of, Therapeutic Services that included self help and improved quality of life.

As one interviewee noted:

We are hoping to make a difference to people's quality of life in terms of health and well being…..giving people tools that they can use at home to continue to improve their health and quality of life, as well as receiving treatments in the clinic.(1)

Within the UK CAM services are typically provided privately on a fee paying basis. The services are thus rationed by ability to pay; access to CAM linked to affordability was highlighted by all those interviewed:

…on the therapeutic services side we all have the same vision to provide a holistic service and give choice to

service users, and to those people out there who are on a low income and benefits to access our service to help them to reduce their stress.(4)

The function is to serve low income patients, and patients that have been referred from doctors. I think the function is to give a good service that some people would not otherwise be able to afford. (2)

Therapeutic Services, as a whole, I understand is that they offer a range of complementary and alternative services that people would not otherwise be able to access because of income or other sorts of circumstances. (3)

However, the latter interviewee goes on to say I've got a very limited grasp of the rest of the service to be honest (3).

Whilst the focus of the vision for the Service lies in the beneficial effects for those accessing it; it was apparent that service providers also benefited from the role they played in the Service. Reasons for this include a feeling of personal satisfaction from helping in a community in which they had roots, to the opportunity to see a varied group of service users outside the narrow range typically accessing CAM.

High Stakes

Clearly the benefits to those working in Therapeutic Services described above provide, as suggested in the Warnwarth framework, compelling reasons to work towards a successful partnership; this was thought to be especially pertinent for volunteers.

I would say that the volunteers that come in here for the body therapies are coming here to get experience. Their intention is to get experience of working in a community setting and working with your basic everyday person, working with a cross cultural client group, because they don't get that in training. So it is mutually beneficial, and they also get the support and guidance for managing the clinical and day to day stuff. So that is a good partnership because we win and they win (4).

In general there was an expression of personal satisfaction and enjoyment in the roles interviewees performed within Therapeutic Services based on the shared vision:

I love being in the community and what we do, we really do make a difference to people's lives. (1)

Right People

Involving the best and most appropriate people was alluded to by a couple of the interviewees who spoke of similarities based on CAM culture:

The culture in therapeutic services is about increasing clients self awareness, and getting them to help themselves, but being a guide and support at the same time. I think the culture here reinforces that because we all have that same calling, and the same aim. (4)

Conversely, differences between team members were also highlighted as a strength giving breadth to the partnership.

For example, two interviewees spoke of the benefit that their local knowledge and understanding of the community brought to their role. Another spoke of the multi-ethnicity and multi-linguality of those working within Therapeutic Services reflecting the community around us (1).

Right Leadership

Leadership within Therapeutic Services was thought to be both effective and supportive with clear line management, clear expectations of what they can expect and what is expected from them. (2) Another interviewee spoke of a good relationship and rapport with the service leader that meant:

if you have a problem or disagree ……(the leader) will take your comments on board. So I think it is balanced, and we all work as a solid team. (4)

Only one interviewee felt they were not clear who led the service.

Strong Balanced Relationships, Trust and Respect

Relationship building within an organisation is likely to be difficult when a service is characterised by a large proportion of part-time workers who often have little physical contact with each other in as much as they work at different times on different days. However, despite this complexity relationships appeared to be strong, the people within Therapeutic Services worked well together and felt a valued part of the service. Whilst the relationship in the partnership wasn't balanced in as much as one interviewee noted

I don't think I have a say in the running of it they went to on say I think that I am noticed and valued(2).

Another interviewee echoed this view:

I really feel valued by 'TS' and by the management (4).

These feelings of being valued were tempered by another interviewee who perceived that:

I think if I make a fuss something will happen….But if I don't make a fuss then it may or may not (3)

Feelings of being trusted and respected were demonstrated by autonomy in the workplace

…when I come here I just get on with it and there's no-one telling me what to do all the time (2)

Good Communication

Good communication was seen to be a vital component of effective leadership and thought to be enhanced by the nature or culture of CAM. As one interviewee noted:

Because of the work… the team have to be really grounded and centred, and I think we communicate really well (1)

Regular team meetings and clinical supervision provide opportunities for discussion that was thought to be enhanced by the small numbers in the team. However, for volunteers team meetings could be perceived to be an unnecessary draw on their time. Opposing views were given by two interviewees. One highlighted the positive aspect of communication, especially for those working part-time and of feeling part of a team;

another wasn't interested in being part of a team (3).

This interviewee went on to say that communication can work fine but it's a bit erratic and it may well be that the service is highly understaffed.

Both service leaders and practitioners talked about having the freedom to discuss and challenging ideas.

Formalisation

Therapeutic services has its own mission statement that outlines the aim of improving the quality of people's lives, health and well-being and reaching people that others might not (1).

Within the managerial structure the CAM manager is responsible for leading the team and within the team a clinical supervisor is responsible for overseeing the team's client and work loads and sharing skills within therapy. Both volunteers and

paid staff have formal contracts; although as one interviewee noted:

I very often ignore those hours (3).

One particular difficulty articulated by a part time volunteer was the lack of clarity in respect of the roles of others in the organisation and the demands on their time. This related particularly administrative help.

Within Organisation Partnerships

The history, structure and context of the Big Life Group have been described earlier.

This part of the report attempts to explicate some of the relationships between these separate but partner organisations under the umbrella of the Big Life Group.

Right Reasons and High Stakes

The documentary analysis revealed a shared vision at an organisational level between Therapeutic Services, the Kath Locke Centre, Big Life Services and the Big Life Group. The vision for Therapeutic Services, in line with the Big Life Group ethos was outlined eloquently by one interviewee:

We are hoping to make a difference to people's quality of life in terms of health and well being…..giving people tools that they can use at home to continue to improve their health and quality of life, as well as receiving treatments in the clinic.

Despite this shared vision, there was for the CAM practitioners interviewed a feeling of detachment from the wider organisation (the Big Life Group and Big Life Services). For these people Therapeutic Services, and to some extent the Kath Locke Centre, was the boundary of their work.

This is understandable given their immediate contact, and indeed contract, is with Therapeutic Services. As one interviewee noted *I'm not involved with Big Life Services or the Big Life Group (2).*

Another that, *sometimes I wonder about the bigger picture of Big Life (4).*

For this group focus lies not in the organisational structure but in the benefits to the community and individual service users and in this their individual visions mirror that of the organisation.

Feelings of detachment are, in part, borne from the organisation's significance to their every day working.

One interviewee articulated their detachment in terms of what happens at the 'coal face':

I have worked within organisations like this and I've fund raised a lot for organisations like this. And rarely does it seem to me that the stated aims appear to have any significance at all.

But there may be sort of general statement of intention, but actually what's significant is the service deliver on the ground to people and whether people find that useful and beneficial in their everyday life.

And that's the only bit of this service that I am interested in. (3)

Strong Balanced Relationships, Trust and Respect, Good Communication and Formalisation

For the interviewees in management roles there was close alignment with and to the overall organisation.

They had a clear picture of the organisational structure and how both they as individuals and Therapeutic Services as an organisation fitted within this structure. As one interviewee explained:

….there is a senior management team. We have the company goals and targets, then they set our targets in line with theirs, and they manage the budgets. They have the overall responsibility of the contract, but the day to day running of it is left to the therapeutic services (1).

Whilst Therapeutic Services do not act autonomously, the relationship is strong and balanced in as much as power is devolved through formalised processes. The relationship is defined by working with, rather than working for:

We have the same aims and objectives, but we influence how we are going to reach our target. One target is "making a difference to people's lives". The company have their own has their own targets and Therapeutic Services set their own in line with the company's (1).

The relationship between the Kath Locke Centre and Therapeutic Services was described as supportive.

The Centre was seen to share their vision and work in partnership with Therapeutic Services.

The Centre provides use of their premises and support events held by Therapeutic Services:

…. the Kath Locke centre pays the therapeutic services from their budget to projects in the community.

They also give us the use of their rooms for free, and support us when we hold events, so I think there is a commitment there.

The chief executive has been around for 12 years and is keen to make a difference and change people's lives (1).

Another noted that it's a lovely place, and the people were so helpful when I first started (2)

Outside Organisation Partnerships

Therapeutic Services work in partnership with many organisations outside the Big Life Group in both the statutory and voluntary sectors. However, the focus of this part of the report is their partnerships with the local Primary Care Trust (PCT) and with the University of Salford. Choice of organisations for this part of the report was informed by historical and current context.

Local Primary Care Trust (PCT)

The Big Life Group has been linked with the National Health Service, and in particular primary care services for over a decade; the Kath Locke Centre, the primary base of Therapeutic Services, was the first NHS primary care facility in England to be managed by the independent sector[19].

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19 http://www.thebiglifegroup.com/Uploads/klc%20evaluation.pdf

Right Reasons and High Stakes

Documentary analysis shows that at the level of the organisation, the vision or aim of Manchester PCT align to those of the Big Life Group:

….to ensure modern, high quality NHS services that are easily accessible for all residents in the city.

We are committed to working with patients, carers and the public to ensure that our services meet and respond to the needs of the diverse communities across the city[20].

The PCT also demonstrate their willingness to enter into productive partnerships in order to achieve this vision:

We will work closely with local partner agencies, particularly Manchester City Council, health professionals such as GPs and dentists, voluntary and community organisations as well as our own staff to achieve this[21].

Therapeutic Services work in partnership with Manchester PCT and have received funding annually from them for over 10 years.

The bulk of this funding applies to the provision of counselling but a small part is allocated for CAM services.

Primary care providers including GPs and the mental health team refer individuals to Therapeutic Services.

However, within Therapeutic Services there is concern over whether their tender to the PCT for funding for the CAM part of the Service will be successful in the medium to long term. The primary reasons for concern, and thus threats to the partnership, are exogenous to the partnership lying in the perceived weak evidence base in CAM and guidelines set down by the National Institute of Health and Clinical Excellence (NICE). As one interviewee noted:

…there's so much there's so much research done on the effectiveness of complementary therapies and yet NICE are still saying that there isn't evidence sufficient enough that it is worth investment and I think that then impacts on everyone's view. And most medicine in this country is given in a very western medical model and treats the actual illness rather than the person as a whole. So, and most of the professionals are trained in that framework, so it's the odd one that thinks differently. So, you know, we've had things like health visitors not knowing whether it would be right to refer to the Homeopathy Service, for instance, because they were saying, well we're giving it some credence and we're giving it recognition in the fact that it is going to be effective if we're referring people (5).

Therapeutic Services concern is that these factors, together with negative media coverage of the effectiveness of CAM, may result in their tender for funding from the PCT being unsuccessful for the CAM element of the Service (excluding counselling services which they perceived will be funded).

Right People, Right Leadership, Strong Balanced Relationships, Good Communication

From the perspective of the working relationship between the PCT and Therapeutic Services was viewed by one interviewee as good at an organisational level but at an individual level the partnership was hampered by people moving around in jobs.

As one interviewee noted:

There is probably one person who has key relationships for funding with the PCT. In terms of the City Council we have built a really good relationship with them. We regularly have meetings (2-3 times a year) There is a consistency within the council as the same person has been in the role for 3 years now (1).

The balance of power in the partnership was thought by one interviewee to be in favour of the PCT in as much as they decided whether or not to fund the service:

I think the power lies in the PCT, my perception of it, I don't know if I'm right but they can open doors to funding for us or not, and originally when they came to replace the Health Authority their main remit was about providing the community with the things that they want and massage was one of them, but… their remits have changed, but ours hasn't (4).

However, Therapeutic Services are taking a proactive stance in order to secure future funding in the tendering process by working with the University to provide a more robust body of evidence and providing for example, courses that people can take skills away from, as we felt this would give us a stronger position for funding next year(1).

For one interviewee

there was the feeling of constantly struggling to provide evidence (4). This was despite having really high demand for all the complementary services that we deliver (5).

20 http://www.manchesterpct.nhs.uk/pct/about/
21 http://www.manchesterpct.nhs.uk/pct/about/

Formalisation

The partnership is formalised in part through the contractual process. The contract has strict criteria to work with specific groups and work in partnership with other agencies (1).

University of Salford

The University and Therapeutic Services have worked in partnership together in the past. This work has included students from the University carrying out research as part of their studies within the Service and, most recently, working in partnership to develop research to evaluate the effectiveness of the CAM services provided.

Right Reasons and High Stakes

The University of Salford fashions itself as an enterprising University with an excellent reputation for research and business partnerships[22]. Their aim is to strengthen these links, developing ideas and encouraging innovation[23].

The vision goes on to say:

What marks us out in national and international arenas is our engagement with local and regional communities – this will remain core to our values as a University[24] *(University of Salford 2008)*

The vision of engagement with local communities and a research focus on solving real world problems[25] can clearly be seen to align itself with that of the Big Life Group and Therapeutic Services. Indeed overall those interviewed within Therapeutic Services perceived partnerships with higher education institutions as beneficial:

I think generally we've had lots of good partnerships, particularly Salford University and there's the integrated complimentary therapy course and things like that. So all the way through the years, you know, and I've been in Salford today and the Health Centres there are talking about taking students on. I think there is a very good relationship generally.

I think we've worked over a number of years to try and find funding to measure effectiveness and we'll continue to look to that kind of partnership because I think that's been useful to us (5).

Not all the experiences were positive particularly in respect of the mixed quality of work produced by students and the paperwork required. One interviewee noted:

We have had student placements in the past, but stopped as it became too time consuming chasing up paperwork, but I think it is something we would be open to trying again (1).

The reason for the current phase of the partnership, to produce robust evidence of the effectiveness of CAM, was clear from the outset. Prior to this current project, Therapeutic Services and the University had worked together to develop a research proposal to evaluate the effectiveness of the CAM services they provided. Unfortunately, the proposal was unsuccessful and was not pursued further at that time due to a change in staff both at the University and at Therapeutic Services. However, dialogue continued between the University and Therapeutic Services to explore ways in which to develop a co-ordinated and systematic outcomes monitoring system in collaboration with

practitioners to facilitate the on-going evaluation of the effectiveness of CAM services by Therapeutic Services. This was thought by both the University and Therapeutic Services to be important for two reasons. While CAM is enjoying increasing popularity and acceptability in the UK existing data on the benefits is based predominantly on the experiences of fee for service clients who come from typically non-marginalised, higher income target groups. There is therefore a need for evidence on their effectiveness for disadvantaged groups who access free or low cost CAM therapies to guide service users in selecting treatments, service providers in developing appropriate CAM services and commissioners in funding the delivery of such services.

It was anticipated that the results would provide evidence with which to support funding for the service.

It was this need for evidence in order to help secure funding for the Service that was paramount and provided a powerful reason for the partnership for both those working in Therapeutic Services and for the University researchers; that a co-ordinated and systematic outcomes monitoring system would help provide evidence that would together with other work being carried out by the Service help secure funding:

Commissioners are impressed by a certain body, which is why being involved with the University could be beneficial.

As this area is the university's expertise it will be taken more seriously. I think it could be a good ongoing process/ relationship (1).

22 http://www.vision.salford.ac.uk/page/our_aims
23 http://www.vision.salford.ac.uk/page/our_aims
24 http://www.vision.salford.ac.uk/page/our_aims
25 http://www.salford.ac.uk/about/

Right People, Right Leadership, Strong Balanced Relationships, Good Communication

The Service managers believed that the project undertaken with the University was carried out in partnership.

Communication of the project to practitioners was initially undertaken by the University through a series of workshops that provided a forum for discussion of the outcome measure that would be used within the therapists' everyday practice.

The workshops led to a number of additional questions to be added to the measure in line with the outcome of the discussions.

Once the outcome measure was introduced, ongoing data collection was overseen by the Therapeutic Services Manager.

Regular contact between the Service and the University, at this time, was typically by either e-mail or telephone.

Communication about the use of the measure across the Service was good in as much as whilst one practitioner was new to the service and was not aware of the partnership with the University the practitioner said that:

t*he forms will show the case studies of each person, and show that the clients are getting better (2).*

Similarly another noted, in respect of the outcome measure:

I think they're quite good. I mean they don't always work, you know, they don't always work in practice.

Theoretically I think they're fine. I have no objection to filling them in at all. I am perfectly happy to do that useful exercise, collection of information (3).

This interviewee went on to say that

sometimes it doesn't work and there's a variety of reasons why it doesn't work… I might just actually forget….. I think the scales are quite useful but, and I will always ask, I will quite often ask patients to mark things anyway. But the scales are quite useful so they can add to my understanding.

Reflections from the Author (CH)

Unlike in the previous subsection, the perspective of the 'other' partner can be explored in as much as it is the author's reflections on the partnership – as such I will write in the first person for this section. Overall I think the partnership was successful in as much as there was a small body of evidence available for Therapeutic Services to use at the end.

The relationship appeared to be both strong and balanced. Each of the partners, both at an organisational and individual level, was aware of their roles and worked to their strengths and expertise. I did not perceive any imbalances of power between myself and the Service manager (with whom I had most contact). We were both were working towards the same goal, and the history of working with Therapeutic Services in the past also helped make this a positive experience for me, as the interviewees comments suggested it was for them.

The interviews with people within the Service were carried out by the second author (PO) who was not involved in the case study in an attempt to minimise bias but, despite the positive comments made by the interviewees of the partnership, I felt that there were some aspects of the partnership that could have been improved upon.

To set this in context soon after beginning the project I moved jobs, going to a different University. This meant that I was geographically remote from Therapeutic Services in Manchester and that I no longer had the time allocated to the project I would have had had I stayed in the previous job. Whilst this did not damage the partnership per se it meant that communication was carried out primarily through e-mail, which was not ideal; I think by being physically present at Therapeutic Services, for example at team meetings, would have increased the numbers of outcome measures completed and thus the success of the project. It also meant that whilst a good working relationship with the Service Manager had been developed this really didn't develop any further as it would perhaps have done with more face to face contact.

My final note is regarding formalisation of the partnership. The history of working with Therapeutic Services meant that, in my mind at least, trust was established prior to this current project. Whilst the partnership was relatively fluid (especially given my job move) I felt that there was clear lines of responsibility and accountability which I don't think waivered over the life of the project. On reflection this was in part due to setting out roles and responsibilities right at the beginning (what could be achieved and by whom) and as a result of the high stakes (to obtain funding for the service).

Further details of the project are included in the project report contained in Appendix 2.

Discussion and Conclusions

The Warnwarth Framework was a useful tool for evaluating the partnership relationships facilitating exploration of both organisational and individual partnerships. However, this should be tempered by saying that there were difficulties in being able to evaluate concepts such as trust and respect from interview data and documentary analysis alone. There is also a danger that in trying to separate out different concepts that the holistic evaluation of the partnership is lost. However, this did not appear to be the case as the concepts within the framework were not mutually exclusive and often either merged or informed one another to provide that holistic view; the framework allowed evaluation of important factors without losing sight of the partnership as a whole. Of particular importance when using the framework were the explanations of the concepts. The authors found the need to refer back to these explanations frequently during the analysis.

The framework was used to explore the partnership within and between organisations. The within organisation analysis shows clear differences between those interviewed in managerial roles and those who are at what was described by one person interviewed as 'the coal face' (the micro, meso, macro analogy described by Warne and Howarth). These differences are likely to have been compounded by both part time working and that some participants were volunteers holding down jobs elsewhere in addition to their work within Therapeutic Services. For these people the strategic aims of the Service and the umbrella organisation held little interest although their vision and aims of the service aligned completely with both.

It is also of note that interviewees mentioned the importance of their partnership with the local community and whilst it was not possible to explore this in detail within this report it is clearly integral to the Service and their umbrella organisation.

Overall partnership at the level of the individual within the Service works well. The culture is one of inclusivity rather than exclusivity and the environment nurturing. Those interviewed attributed this to good leadership and, importantly, to the culture within CAM itself (which was seen as seen to attract people who were nurturing and good communicators). Whilst some dissatisfaction was expressed this was primarily associated with understaffing and linked to funding of the Service and clarity of roles in administration. Difficulties in this area were exacerbated by the complexity and logistic difficulties of a staffing mix of volunteers, paid staff, full and part-time contracts. However, the majority of those interviewed felt that clarity of role and good communication was facilitated by the right people, right leadership and systems in place.

The evaluation of the organisational partnerships was hampered to some extent by inclusion of the perspective of only those in Therapeutic Services. Whilst this makes some of the conclusions relatively uni-dimensional it was possible to explicate the dynamics of the partnerships and draw some conclusions about the partnerships relative success. For the organisations within the Big Life Group the documentary analysis provided, perhaps unsurprisingly, a clear alignment of their visions; of a shared vision and clear structure. Whilst this was echoed by those interviewed who were in managerial roles, as mentioned previously for the

people working at the 'coal face' the organisations above Therapeutic Services in the hierarchical structure held little interest and this was vocalised by one interviewee as a feeling of being detached. For this group, especially those who worked part time, there was little reason to come into contact with these organisations (other than the Kath Locke Centre) in their work.

There has been a long and successful partnership between the local PCT and Therapeutic Services at an organisational level evidenced by over a decade of funding from the PCT which, together with funding from other sources, has allowed the Service to be sustained and expanded over time. Whilst the on-going commissioning of counselling services do not appear to be of concern, some of those interviewed from Therapeutic Services voiced concern over funding for CAM services, in particular massage, despite high levels of demand. The asymmetry of knowledge regarding funding means that there is a power imbalance in the partnership in favour of the PCT that is typical in any partnership that involves tendering for funding as organisations priorities and remits evolve over time. However, Therapeutic Services have been proactive in addressing this, as one interviewee noted:

At a local level all we can do is demonstrate the effectiveness of the service…I think we've got to make a strong case for why they should keep it in (5).

At the level of the individual, movement of staff within the PCT meant relationship building was difficult.

Details of the partnership with the University given by the interviewees were relatively brief but the reason for the partnership was clear (as demonstrated in the above quote); the interviewees were vocal about the benefits based on the potential for the outcome measure to provide evidence of effectiveness (and potentially help secure funding for the Service) and to aid practice. The paucity of interview data, or indeed opinions regarding the partnership with the University relative to the other partners may be due to the lack of physical presence within the Service workplace. Communication, once the workshops had been completed was typically by e-mail and telephone between the author and the Service manager. However, despite the lack of physical presence the study was successfully complete and each person interviewed was clear about their role in the collection of data and the reasoning behind that collecting it.

References

* Note for the purpose of this report all information retrieved from websites have been included as footnotes attached to the relevant text

DTI (2002). Social Enterprises, A Strategy for Success, Department of Trade and Industry, London.

Warne, T., Howarth M (2009). Developing the Warnwarth Conceptual Framework for Partnership Evaluation: A review of the Literature. Salford Centre for Nursing, Midwifery and Collaborative Research, University of Salford.

APPENDIX ONE

Urban Regeneration - Interview schedule:

Researchers: Claire Hulme and Paula Ormandy

Service Leaders/providers:

Q		Warnwarth Reference
	I want to talk to you because you're a key person concerned with the CAM service	
1	Could you begin by explaining what see the function of the CAM service to be? Promoting health and well-being? What does that mean to you? What should the service be doing?	RR
2	How well do you think the service fulfils its function? Can you give examples of anything the service has achieved in improving health and well-being? Reasons? Are there things that it set out to achieve that have failed? Reasons?	HS (outcomes)
	As you know, the aim of this study is to determine the way in which partnership working impacts upon the health and well-being of local communities.	
3	In considering this, can you tell me what you think the phrase 'partnership working' means in relation to your involvement with the CAM service? Would you describe the service as being a partnership? If so, what sort (formal, network, loose arrangement, steering group, talking shop etc)? What partnerships exist? Who are the commissioners? How does this work? Their level of involvement/engagement? Higher education partnership?	RR (but might touch on all of them!)

Q		Warnwarth Reference
4	What made you get involved in the CAM service? Personal interest? - Role As agency representative?	RR, HS, RP
5	Is there a formal agreement on the purpose of the service? If so, was it used, was it influential? If not, should there be/have been one?	F
6	How is leadership of the service decided? Was everyone content with this process / clear process Do you feel the leadership is effective -- if so how? How do the practitioners relate to the leader?	RL, SBR
7	Did you have professional dealings with the service funders/ in other forums and settings prior to setting up the service? If so, do you think it influenced your role and behaviour in the service? History of working together?	SBR, TR
8	What is your role in the service? Has this changed since it was first conceived? If so how, why etc?	RR, HS, RP, TR(?)
9	What are communications like? Within the practitioners/team? Within the organisation with regard to the service? With the commissioners?	GC, F

Q		Warnwarth Reference

10	What is it like being a member of the CAM service team?
	
	    Do you think your opinions are valued and listened to?
	
	    Is there trust and respect between team members/practitioners?
	
	    What are relationships like?
		RP, RL,SBR,TR

11	Are there some practitioners who get more benefit from being involved in the service than others?
	
	    Or less?
	
	    Or where the purpose of their involvement is unclear to you
		RR, HS, RP

12	Is there a commitment to the service? If so from who?
	
	    Within the organisation
	
	    From the funder's/commissioners
	
	    within the team
	
	    from users
		RR, HS

13	How does culture impact on the service?
	
	    culture within the organisation (power, politics,
	
	    culture within the community (access, recognition of service, competing agendas/ pressures in society)
		HS, RP, RR

14	Where does the power lie within deciding the future of the service?
	
	    Who will be involved?
	
	    How will this be achieved?
	
	    What influence will the team have?
		HS, RP, RR, RL, SBR, (TR)?

15	Does the service have the appropriate resources?
	
	    Sufficient resources to meet the demand? (skills within the team, number of available practitioners)
	
	    Financial constraints?
		F, RP

Q		Warnwarth Reference
16	What is the future vision for the service and the community? How will this be realised? What partnerships are required to enable this to happen?	RR, RP, SBR
	The questions I have asked you have inevitably focused on our own principal concerns	
17	Are there things which we have not covered but which are important in enabling partnerships to promote health and well-being in the community?	

Key - Factors which influence successful partnership working, taken from the 'Warnworth Conceptual Framework', pp 46-9 (Warne and Howarth, 2007):

RR	Right reasons
HS	High stakes
RP	Right people
RL	Right leadership
SBR	Strong, balanced relationships
TR	Trust and respect
GC	Good communication
F	Formalisation

APPENDIX TWO

Dr Claire Hulme[26]

Report prepared on behalf of Big Life Therapeutic Services as part of Urban Regeneration: Making a Difference Project, Supported by HEFCE (Strategic Development Fund)

February 2008

Acknowledgements

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Report for Therapeutic Services

Background

Big Life Services provides and promotes services to improve the well-being of people who have been excluded from mainstream society. Following a self-help and developmental approach, it focuses on the power of opportunity to change people's lives. The organisation has, for over a decade, provided free and reduced fee access to selected complementary and alternative medicine (CAM) therapies in the Manchester area. The sessions are provided on a volunteer basis by trained and accredited practitioners. In addition a number of sessions are commissioned. Sessions are targeted towards persons at the margin of society either through homelessness, chronic long term unemployment or (mental) ill-health, or through their membership of particular minority ethnic groups.

While complementary and alternative medicine (CAM) is enjoying increasing popularity and acceptability in the UK existing data on the benefits is based predominantly on the experiences of fee for service clients who come from typically non-marginalised, higher income target groups. There is therefore a need for evidence on their effectiveness for disadvantaged groups who access free or low cost CAM therapies to guide service users in selecting treatments, service providers in developing appropriate CAM services and commissioners in funding the delivery of such services.

Aim

The aim of this case study is to evaluate the effectiveness of CAM services provided the Big Life Services.

The purpose of this report is to describe and report on the evaluation of CAM services provided the Big Life Services.

Methods

The research was undertaken within the CAM service delivered at the Kath Locke Centre, Hulme, Manchester using a before and after type study design in which service users were asked to complete a questionnaire at three points in time. The questionnaire was an adaptation of an outcome measurement tool appropriate to CAM interventions with disadvantaged groups, MYMOP[27] (Measure Your Medical Outcome Profile). This was used together with existing assessment paperwork (developed via consultation with the Complementary Therapy Manager). The practitioners/therapists were given advice/support in order that they may administer the questionnaires to their service users. The outcome measures were administered at three points in time (at the first treatment session (initial consultation), one month after the first treatment and three months after the first treatment) to measure short and longer term effects of engagement with CAM.

- At the first treatment session the questionnaire was administered by the practitioner.

- Where possible the practitioner administered the questionnaire at the one month follow up. If the client had finished his/her treatment either a follow up questionnaire was sent by post and included a stamped addressed envelop for return or the questionnaire was completed over the telephone.

- Where possible the practitioner administered the questionnaire at the three month follow up. If the client has finished his/her treatment either a follow up questionnaire was sent by post and included a stamped addressed envelop for return or the questionnaire was completed over the telephone.

The time frame of the case study was 9 months. Data collection began in June 2007. Recruitment took place over a 6 months period beginning in June 2007.

The practitioners were responsible for data collection as part of their practice and were supported by the researchers from the University of Salford. All completed questionnaires were held by the service. Any data passed to the University of Salford for analysis was anonymised. Ethic approval for the evaluation was obtained from the University of Salford Ethics Committee.

27 http://www.pms.ac.uk/mymop/index.php?c=welcome

Findings

Sample: Baseline

Overall 32 people completed at least one of the questionnaires; five had received homeopathic services and the remainder massage. Of the people who had received homeopathic services only one had completed a questionnaire at all three time periods. Thus the focus of this report lies upon those in the latter group, massage services.

Twenty seven people who had had some form of massage completed at least one questionnaire; eighteen of those completed questionnaires in all three time periods. The massage services received by those in the sample were described by the practitioners as: massage, aromatherapy massage, reflexology and acupressure. The massage areas included back, neck, leg, face, shoulder and feet.

The majority of those receiving massage were female (n=23, 85.2%). Age ranged from 34 years to 82 years with a mean of 57.4 years. Each person was asked to choose one or two symptoms which bothered them the most. For the purpose of this analysis the first symptom has been classified as the primary symptom and the second as the secondary symptom.

Almost half of those in the sample (n=13, 48.1%) presented primary symptoms related to muscle or joint pain. Other primary symptoms included tension/stress (n=6), emotional issues (n=2), low energy/fatigue (n=5) and period pain (n=1). Participants rated the severity of the symptoms over the past week (0 as good as it could be; 6 as bad as it could be). The mean rating for their primary symptom was 4.2 (range 0-6). Almost half (n=6; 46.2%) of those presenting with muscle or joint pain

rated their symptom at either 5 or 6. Twenty people gave details of how long they had had the symptom (either all the time or on and off). Sixty percent (n=12) had had the problem for over one year.

Secondary presenting symptoms were given by 20 people and these included muscle or joint pain (n=10), tension/stress (n=5), emotional issues (n=1) and other (n=4). This latter category included bladder and bowel symptoms and circulatory problems. The mean rating of the secondary symptoms was 3.9 (range 0-6). The lower mean rating suggests that these symptoms did not bother participants as much as the primary symptoms and, indeed the difference between the primary and secondary symptoms rating was statistically significant (p=0.012). Of the 20 participants who gave details of two symptoms 11 gave the second symptom the same rating as the first, just one gave it a higher rating (indicating that it was worse).

Only eight people said they were taking medication for the symptoms they had described; four of these said that cutting down this medication was important. A further six said that avoiding medication for their problem was important to them.

Participants were asked to give details of an activity that was important to them and that their symptom makes difficult or prevents them doing. Nineteen people answered this question. Of these, two people said that it did not prevent them doing anything, six said sport or exercise, five outlined activities of daily living (including getting out the bath or chair) and two referred to social activities. The four other responses described activities using physical strength, sleeping and hobbies. Again they were asked to rate how good or bad this was; the mean score was 4.2

(range 2-6).

Participants were asked to rate their general feeling of well-being over the last week; again this was on a scale of 0 (as good as it can be) to 6 (as bad as it can be). The twenty four people who answered this question gave a mean rating of 3.4 (range 0-6).

Baseline of Those Completing Questionnaires at all Three Time-points

Nineteen people completed questionnaires at all time-points (the initial consultation, one month and three months after the initial consultation). The mean age of these 19 was only slightly higher than for the sample as a whole (59.5 years); 17 were female (89.5%). The primary symptom for 57.9% (n=11) was muscle or joint pain; four people cited tension or stress, one emotional issues and three low energy or fatigue. Participants' rating of the severity of their symptoms over the last week was 4.2. This mirrored the rating of the overall sample. Just under half of the participants (n=8) rated these symptoms at either five or six (where six represents as bad as it can be). These ratings were across symptom categories (n=5 muscle and joint problems, n=1 tension or stress and n=2 low energy or fatigue). Fourteen people gave details of the duration of their primary symptom. Ten had had the symptom on or off for over a year, one for between 3months and a year and the remainder for less than three months. Six participants who had had their primary symptom for over a year presented with muscle or joint problems. Seven participants indicated that they were taking medication for their primary symptoms.

Secondary symptoms, when included (n=13), were muscle or joint pain (n=9), tension or stress (n=3) and circulatory difficulties (n=1). The mean rating for these symptoms was 3.8 (0-6). All those who rated their symptoms as bad as it could be during the last week (n=3) presented with muscle or joint problems. Eight participants gave their secondary symptom the same rating as their primary symptom; five gave a lower rating indicating that the problems had not been as bad over the last week as the primary problem.

Participants were asked to choose one activity (physical, social or mental) that is important to them and that their problem makes difficult to do or prevents them doing. They then rated this activity (0=as good as it could be; 6=as bad as it could be). Of the 14 people who completed this question two people said that it did not prevent them doing anything, four said sport or exercise, five outlined activities of daily living (including getting out the bath or chair) and two referred to social activities. The three other responses described activities using physical strength, sleeping and hobbies. Again they were asked to rate how good or bad this was; the mean score was 4.6 (range 2-6).

Finally participants were asked to rate their general feeling of well-being over the last week. Seventeen people answered this question and there responses gave a mean rating of 3.1 (range 0-6).

Overall it should be noted that this sub-sample of participants did not differ from the sample as a whole.

One Month after the First Consultation

In the second questionnaire participants again rated their symptoms over the last week. The mean rating of the primary symptom showed an improvement compared to the same participants previous rating (a decrease from a mean value of 4.2 to a mean value of 3.4). This improvement was statistically significant (p=0.012) and was made up of ten participants whose rating improved, six gave the same rating and two gave a worse rating (one participant did not give a score). Similarly the mean rating of the secondary symptoms decreased from 3.8 to 3.3 (range 1-6) indicating an improvement. This was not however statistically significant and comprised of 13 participants three of whom rated their symptoms worse than previously, four the same and six improved.

In respect of activities that participants felt their problem made difficult to do or even stopped them doing, again the change in rating for this group of participants represented an improvement (4.9 initially to 3.63). Nine participants completed both this question at both time points (five ratings improved, three remained the same and one worsened).

Participants' ratings of their own general well-being over the last week saw a slight improvement from 3.1 to 2.9 over the two time periods. Of the 14 people who completed the question at both points, five rated their well-being better, six the same and three worse. In addition participants were asked how they would describe their general feeling of well-being over the last week when compared to when they started with the programme.

Fifteen people completed this question: six indicated they felt much better than at that time, six somewhat better, two about the same and one worse.

Three Months after the First Consultation

The 19 people who completed both the first questionnaire and second questionnaires also completed a further questionnaire three months after their initial consultation. In this third questionnaire participants again rated their symptoms over the last week. Again the mean rating of the primary symptom showed an improvement compared to the same participants previous rating (a decrease from a mean value of 3.4 to a mean value of 2.9). This improvement was statistically significant (p=0.028) as was the improvement between baseline and three months (p=0.06). Between one month and three months after the initial consultation two participants rated their primary symptom worse (i.e. a higher rating), seven the same and nine better (one person didn't complete this question). Similarly, the difference in ratings between baseline and three months showed one worse rating, six the same and eleven better (again one person didn't complete this question. The mean rating for the secondary symptom was 2.2 (range 0-4). This represented an improvement in symptoms from both one month after initial consultation (mean 3.8) and from baseline (mean 3.3).

Seventeen people rated their general-well being over the last week; this gave a mean rating of 2.4, again an improvement when compared to both the previous time periods. This is further corroborated by participants' classification of their general feeling of well-being over the last week when compared to when they started with the programme. Of the fourteen people who completed this question seven indicated much better, four somewhat better and three the same. Twelve of these participants had also given the duration of their primary symptoms. Of the eight who had had their symptom for a year or more, six reported that their general feeling of well-being over the last week when compared to when they started with the programme much or somewhat better and two about the same.

Participants were also asked if they had any other comments that they would like to make about their general feeling of well-being since starting the treatment. Whilst few added anything the five who did all highlighted, either explicitly or implicitly, a feeling of relaxation:

Client says that she sleeps right through following reflexology (client presented with sleep disturbance)

Relaxed (client presented with pain and stiffness)

Client thinks the treatment is very good and relaxing; felt relaxed and able to deal with issues better; and sleeping at night (client presented with stress)

I feel much more relaxed and not much tension around my neck and shoulders thanks to the treatment. I feel much better in general compared to when I first started the treatment – I would strongly recommend massage (client presented with tension in neck and shoulder)

Conclusion

Overall the questionnaires show that those using the service perceive that there has been a positive improvement over time in their symptoms and general feeling of well-being. Whilst this cannot be directly attributed to the treatment received, it is important to note that some participants who had presented symptoms of long standing reported an improved feeling of general well-being.

Despite the small sample size, which means that statistical significance should be treated with caution, the reported findings to individual questions corroborate each other in as much as reported improvements in symptoms are accompanied by reported improvements in activity and general well-being. In addition the improvements were evident both at one month after the initial consultation and at three months after the initial consultation.

Of particular concern to the practitioners during the planning stages of the evaluation was the perception that numbers on scales did not reflect the service users real feeling of well-being – that words/qualitative data would give a truer picture (particularly the clients' own words). To address this in addition to the scale for well-being a categorical general well-being question was added (much better, somewhat better, about the same, somewhat worse and much worse). The two questions were placed on different pages within the questionnaires. The responses to the questions reflected each other which suggest the scales were less problematic than anticipated.

This section outlines limitations of the evaluation and presents recommendations in respect of how these may be addressed in the on-going evaluation of the service.

Limitations

The small sample numbers mean that the findings reported for this sub-sample they are unlikely to be generalisable. In addition further detail in respect of the number and nature of treatment sessions each participant received is needed. Although differences between some sub-groups are outlined, again these are only indicative.

Whilst the majority of participants reported an improved feeling of well-being and improved symptoms little data is available to illuminate the findings. The qualitative comments given by a small number of participants are indicative of feeling more relaxed which for one participant meant improved sleep and for another participant less tension in their neck and shoulders.

A further limitation was the missing data on the questionnaires which meant for some responses there was little data to report. This particularly related to medication. Unfortunately the data for the medication questions was sparse and as such has not been reported in any detail.

Recommendations

This initial report and the database provide a sound basis for on-going data collection and evaluation for Therapeutic Services which is a credit to the hard work of both the service manager and practitioners within the service. The main limitation of the evaluation is the small sample number but this will be rectified over time as the sample numbers increase.

This part of the report makes a number of recommendations in order to improve the evidence provided, to make the evidence more robust and thus increase generalisability; and to build on the work already carried out within the service. The recommendations made take into account the burden placed on the service, practitioners and users.

Data Collection Forms

Include the following within the data collection forms:

• Details of the total number and frequency of treatment sessions. This will enable comparison between the effectiveness of therapy based on number and frequency (for example, are weekly sessions for three to four weeks more effective than the same number of sessions carried out fortnightly?)

• More details of the type of therapy. Within this report it was not always possible to distinguish satisfactorily between, for example reflexology or back massage. This may be important, for example, in terms of the effectiveness of treating different symptoms

• Further demographic detail will be valuable (include for example, employment status and ethnicity[29]). This will allow analysis in respect of which demographic groups are taking up the service and aid longer-term planning in targeting the service to particular groups

• Details of whether the service user has had CAM before

Practitioner Training

Missing data, in the form of unanswered questions, was problematic. Given the difficulties associated with staff turnover within the evaluation period further training in administration of the questionnaire is likely to be beneficial and will address this. In addition reinforcement of the importance of evaluating the service is vital for both for the practitioners own continuing professional development (providing evidence of the effect of the therapy they provide) and for commissioning purposes.

Notes

Summary: Key factors to ensure successful partnerships

Authors: Karen Holland, University of Salford

As noted by Holland, Warne & Howarth (2008: 25) there are key factors to ensuring successful partnerships, all of which have been identified in the Case Studies through both evaluation of the Warnwarth Conceptual Framework, the literature and the experience of the project team members:

• Establishing the right reason for setting up the partnership initially

• Ensuring the partnership is the right size to enable effective working and collaboration

• Developing a shared vision of what the partnership is trying to achieve and the benfits involved

• Agreeing the contribution of each partner to achieving the aims of the partnership

• Assembling the right people in the partnership - not only from the right organisations but people who are able to contribute appropriate knowledge and experience, have sufficient autonomy to represent the views of their community or organisation and can communicate ideas effectively

• Ensuring you have the right leadership -in terms of being effective and having strong interpersonal skills that foster respect, trust, inclusiveness and openness among partnership members

• Developing a shared understanding of what each partner brings and also agreed ground rules from the outset about how the partnership will work and manage its task(s). The latter is very much dependent on the partnership lead and their ways of working

• Making sure all contributions to the partnership should be valued and respected

• Effective communication is essential, both in relation to direct partnership working at meetings but also between meetings and how partners communicate the work of the partnership to others

• Ensuring, as part of setting the ground rules for ways of working, that issues such as how the partnership is managed and conducted, and to whom it is accountable, are transparent to all involved

Reference

Holland K, Warne T & Howarth M (2008) is 'good enough' good enough? Learning Curve, New Start, 3rd October, 2008, 24-25.