

1 The concepts of partnership and collaboration

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This chapter will:

- Examine key concepts that will be referred to throughout the book, such as working together, partnership and collaboration.
- Use a concept analysis framework to analyse and explore key concepts and outline their distinguishing features.
- Highlight similarities and differences between the concept of collaboration and the concept of partnership and contextualize these differences within the current health and social policy agenda.
- Discuss the implications of partnership and collaboration for effective working together and how they are understood and operationalized by professionals from different agencies.

Collaboration, partnership and working together: the use of language

Within health and social care literature, there are many references to the need for health and social care agencies to ‘work together’ more effectively in ‘partnership’ and in ‘collaboration’. A recent example can be found in the Department of Health’s (DoH 2007d) policy for tackling health inequalities, which requires local service providers to work in partnership to address the wider determinants of health such as poverty, employment, poor housing and poor educational attainment with primary care trusts and local authorities being the key partners, leading and driving change locally.

Partnership and collaboration are often used inter-changeably, sometimes within the same paragraph or even sentence. Much use of the terminology is policy driven, giving way to the use of terms such as ‘joined-up thinking’ and ‘joined-up working’; for example, *Every Child Matters* (DfES 2004: 9) states that progress in improving educational achievement for children and young people in care and in improving their health has been possible through better joint working.

As a preliminary, we think it worthwhile to broadly distinguish between what something is (a partnership), and what one does (collaborate or to work together in a joined-up way). This chapter will initially distinguish what different models of partnership are in current use and then go on to look at the way these different partnerships actually work. One thing that emerges from this discussion is the way that theory (what a partnership is) and practice (what it does) can often drift apart. Sometimes partnership may be nothing more than rhetoric or an end in itself, with little evidence that partners are genuinely working together. Equally, it is possible for different agencies to work collaboratively together without any formal partnerships being in place. It is important, therefore, to tease out the relationships between these concepts so that we can be clear about how effective they are in practice. However, before doing this, we want to say something about the current philosophical and policy context in which these definitions and arrangements have begun to be developed.

Partnerships: philosophy and policy

We live in what many commentators refer to as a post-modern world (Lyotard 1992). Philosophically or theoretically, post-modernism is a critique of the older 'modern' forms of social health and welfare, the 'one size fits all' policy that characterized the post-war creation of universal health and welfare provision. Lyotard argues that these huge national schemes or 'grand narratives' have failed to help the people they were created to help. He cites the examples of poor housing and poverty as social problems that have increased rather than diminished in the last 50 years. Lyotard sees these attempts at social amelioration as more about helping the system rather than the people who need the help. This critique of large scale attempts to solve people's problems has been reinforced by critiques outlining the disempowering effects of professional solutions to social problems. Beginning in Britain in the 1980s, both the system and the professionals within the system have been seen as disempowering for clients and receivers of services, with terms used such as the 'nanny state' or the 'disabling state'. Currently these critiques have resulted in an increasing emphasis on service user or 'consumer' choice. Health and social care services have been encouraged to allow consumers to become more involved and to have more of a say in the design and provision of services. Part of the reason for this refocusing on service users as active consumers rather than passive recipients of services may simply be that health and social problems have become more complex and multi-dimensional and that the older more static models of welfare have outlived their usefulness. In the past, the Department of Health has focused on 'health' issues, while social services departments have reacted to the rise in 'social' problems. This is increasingly seen as too simplistic a way of tackling more difficult and intractable problems. There is, for example, undoubtedly a close relationship between illness and poverty.

It is in the context of putting service users at the centre of health, social care and criminal justice, that partnerships have become more necessary. Service user problems, which may be complex and requiring input from a number of services, are more important in designing services than the traditional, centralizing distinctions

between, for example, social workers and community nurses, or between social workers and criminal justice workers. A community may have a need or problem that is peculiar to that particular area. For instance, Bournemouth may be more in need of specialized care for older people than are other areas. A service user with a health problem might need a particular package of care that was previously provided by both the NHS and social services. In the new way of working, both health and social care might join up to provide a seamless 'one stop shop', which meets service users' needs. People's needs may change over time and place and so partnerships may be formed to respond to particular problems.

However, while most people would agree that clients should participate and be involved in the choices that affect their lives, two more practical implications need to be sketched out. While both are closely related, the more important consequence of this shift to a 'problem oriented' approach to health and social care is the inevitability of the disappearance of discrete professions such as nursing and social work. With the emphasis of social care and health changing to meeting local needs through local solutions, the rationale for a generic training might disappear. Moreover, professional 'expertise' is often viewed with suspicion. It is reasonable to suggest that current models of partnership, which are organized around current professional identities, will give way in the long-term to 'problem specific' professions. Within this book there are numerous examples of problem specific professionals focusing upon specialisms as diverse as Gypsy Travellers, victims of domestic violence and drug abusers, to name but a few, but what is evident from their writing is that they can demonstrate explicit examples of working in partnership. Moreover, as Merrell points out in Chapter 3, partnership should not just involve professionals, but should also involve people from disadvantaged groups. It is important that this changing political context provides a background for our current ideas of what partnerships are and what they do. In the next section, we will examine what partnership models are currently in use in health and social care, using Walker and Avant's (1995) concept analysis framework. The process of conducting a concept analysis is useful in that it can clarify the meaning of a single concept (Cahill 1996). Using a concept analysis framework and drawing on examples within the rest of the book, this chapter will therefore:

- define partnership and collaboration
- explore attributes of the concepts
- identify 'model', 'related' and 'contrary' cases of the two concepts
- discuss the antecedents to and consequences of the concepts

Partnerships and collaboration: what are they?

Using Walker and Avant's (1995) concept analysis framework first requires us to seek as many definitions of the terms as possible, including dictionary definitions and definitions used within the literature.

The concept of partnership

Looking at definitions of 'partnership' and 'collaboration' reveals some interesting similarities and differences between them. Dictionary definitions of the term 'partnership' are in Box 1.1 and Table 1.1 (towards the end of the chapter). We have also added web-based definitions to those offered by dictionaries.

Box 1.1 Definitions of partnership

Collins English Dictionary (1991):

- Equal commitment
- The state of being a partner

The Concise Oxford Dictionary (1992):

- To be one of a pair on the same side in a game
- A person who shares or takes part with another, especially in a business firm with shared risks and profits

Web definitions:

- A type of business entity in which partners share with each other the profits or losses of the business undertaking in which all have invested'. See: en.wikipedia.org/wiki/Partnership (2007)
- 'A contract between two or more persons who agree to pool talent and money and share profits or losses'. See: wordnet.princeton.edu/perl/webwn (2007)

What is evident from the definitions is the notion of sharing and agreement, with particular emphasis on business. Despite the availability of definitions, however, Taylor and Le Riche (2006) in a literature review, found conceptual confusion about partnership to be rife in the theoretical and empirical literatures and argue that the concept is loosely defined and expressed through multiple terminologies.

The reference to business partnerships is interesting given the recent trends in health and social care. Use of the term 'partnership' in health and social care settings is strongly influenced by policy, and policy changes quickly. Thus, because terms like 'partnership' are closely allied to policy they can change across time and place as the context changes. For this reason, it is also useful to consider an alternative concept analysis framework (Rodgers 2000), which takes into account the 'context' of the concept. This is illustrated by Gallant et al. (2002), who describe how partnership has changed over the past five decades. First, there was an emphasis on an equitable, just and free society enshrined within the International Declaration of Human Rights (United Nations 1948). Thirty years later, the World Health Organisation (WHO/

UNICEF 1978) stated that citizens should be enabled to become more self-reliant and take control over their own health. Finally, by the end of the twentieth Century, writers such as Frankel (1994) were commenting on how a better educated and informed public have begun to challenge the quality of services provided and are searching for more meaningful interactions with service providers. This change in policy is poignantly reflected in Minhas's personal account in Chapter 16 of this book, which traces his experiences of accessing health, social and educational services during the past 40 years.

This need for partnerships between service providers is reflected in policies emerging at the end of the last century, when community development (NHS Executive 1998) and joint employment, education and deployment of staff (DoH 1999a), were viewed as necessary to solve local problems in partnership with statutory agencies and meet the needs of the local population. Since then, partnerships between professionals and clients have also been emphasized. For example, *Building on the Best* (DoH 2003b), states that 'people want to work in partnership with clinicians, to draw upon the essential knowledge, skills and experience of healthcare professionals, but they also want to be able to contribute their own knowledge about their condition and their own perspective on what matters most to them' (DoH 2003b: 40). Indeed Greenall (2006) found that patients placed more emphasis on the need to be valued as a partner in the therapeutic relationship with the team (particularly the physician) than they did the issue of use of technology and distribution of staffing and funding. Further emphasis has also been placed on partnerships between agencies; *Choosing health*, for example, states that effective local partnerships, in which local government and NHS work towards a common purpose, are key to its success. Furthermore, as a result of *Choosing Health*, community collaboratives have been set up to support action through local partnerships.

It is clear then that current policy emphasizes a 'three-way partnership' between health and social care providers and service users, in which there is joint agreement about what services should be provided and by whom, with joint employment, community development and teamwork seen as means of breaking down existing professional barriers and responding to local needs. What the above definitions and rhetoric therefore implies is that of a partnership as a *shared commitment, where all partners have a right and an obligation to participate and will be affected equally by the benefits and disadvantages arising from the partnership*. What a commitment amounts to may vary from one context to another. In the next section, we will trace the limits of what a commitment could amount to. In addition, talk of rights and obligations implies that all parties in a partnership must work to high ethical standards. In effect, this has implications for collaborative working, as this would be substantively defined in ethical terms. This is discussed in Chapter 4 in terms of the moral obligations placed on professionals when they work together and the fiduciary relationship, which characterizes the features of a client-professional relationship in which both parties are responsible and their judgements are given consideration.

The concept of collaboration

Dictionary definitions of ‘collaboration’ are in Box 1.2 and Table 1.1 (which is located towards the end of this chapter).

Box 1.2 Dictionary definitions of collaboration

The Concise Oxford Dictionary (1992):

- Cooperate traitorously with an enemy
- Work jointly

Web definitions:

- The process by which people/organizations work together to accomplish a common mission. See: wind.uwyo.edu/sig/definition.asp
- A social skill involving working together with two or more persons. See: www.dpi.state.nc.us/curriculum/artsed/scos/music/mglossary

Table 1.1 Attributes, antecedents and consequences of partnership and collaboration

	Partnership	Collaboration
Defining attributes	Trust and confidence in accountability Respect for specialist expertise Joint working Teamwork Blurring of professional boundaries Members of partnerships share the same vested interests Appropriate governance structures	Trust and respect in collaborators Joint venture Team work Intellectual and cooperative endeavor Knowledge and expertise more important than role or title Participation in planning and decision making Nonhierarchical relationship Sharing of expertise Willingness to work together towards an agreed purpose Partnership

	Partnership	Collaboration
	<p>Common goals</p> <p>Transparent lines of communication within and between partner agencies</p> <p>Agreement about the objectives</p> <p>Reciprocity</p> <p>Empathy</p>	<p>Inter-dependency</p> <p>Highly connected network</p> <p>Low expectation of reciprocation</p>
Antecedents	<p>Individual, local and national initiatives</p> <p>Commitment to shared vision about joint venture</p> <p>Willingness to sign up to creating a relationship that will support vision</p> <p>Value cooperation and respect what other partners bring to the relationship.</p>	<p>Educational preparation, maturity and experience to ensure readiness</p> <p>Understanding and acceptance of role and expertise</p> <p>Confidence in ability and recognition of disciplinary boundaries</p> <p>Effective communication, respect for and understanding of other's roles</p> <p>Sharing of knowledge, values, responsibility, visions and outcomes.</p> <p>Trust in collaborators.</p> <p>Nonhierarchical organization with individual autonomy</p> <p>Willingness to participate in formal, structured joint working to the extent that they do not rely on reciprocation in order to ensure that each contributes to the shared vision</p>
Consequences: <i>Benefits</i>	<p>Social exclusion tackled more effectively through multi-disciplinary action</p> <p>Less repetition of service provision from different organisations</p> <p>Less dilution of activities by agencies</p> <p>Less chance of agencies producing services that are counterproductive to each other</p>	<p>More effective use of staff due to cooperation rather than competition</p> <p>Demystification of healthcare due to bridging of gaps between fragmented service provision</p> <p>Sustained energy</p> <p>Cross-pollination of ideas</p> <p>Sharing of effort and ultimately sharing of organizational structure</p>

	Partnership	Collaboration
<i>Barriers:</i>	Complexity of relationships. Representativeness of wider public Tokenism and excessive influence of vocal groups Desire of individuals not to be involved in making decisions about their care Threat to confidentiality. Role boundary conflicts Inter-professional differences of perspective Threats to professional identity	

These two very different dictionary definitions perhaps reflect the change of emphasis in health and social care over recent decades. Hence, the *context* of the concept (Rodgers 2000) is as important for understanding the concept of collaboration as it is for understanding the concept of partnership. During the 1980s there was considerable suspicion between the health and social care professions, to the extent that working together would have been regarded as problematic. However, recent policy reforms have encouraged different professional groups to break down barriers and to work together collaboratively. It is these changes that have given way to the development of more formal partnerships. It is interesting that a common language of 'working together' and 'breaking down barriers' draws together the two concepts of partnership and collaboration. The close proximity of definitions relating to these two concepts is also reflected in Henneman et al.'s (1995: 104) definition of collaboration as being frequently 'equated with a bond, union or partnership, characterised by mutual goals and commitments'.

More recently, the rhetoric around partnership and collaboration is beginning to give way to alternative terms, such as 'working together', as seen in the contemporary web definitions of collaboration, with their emphasis on social skills required to work together towards a common goal. In fact, Burke (2001) cites Service Level Agreements (SLAs) as an example of how different agencies have been encouraged to *work together* by the government, thus drawing up SLAs lasting three to ten years, which should be based on health improvement programmes.

Exploring the attributes of partnership and collaboration

Walker and Avant (1995) propose that once definitions and uses have been identified, the defining attributes of the concept should be explored (see Table 1.1). These attributes are found in the literature, and help to differentiate between similar

concepts. In this case, this process will help to differentiate between the concepts of 'partnership' (who we are) and 'collaboration' (what we do).

Attributes of partnership

Within the literature, there is much reference to the characteristics of partnership. Characteristics referred to include: trust; the need for partners to share the same vested interest; the need for appropriate governance structures (Gannon-Leary et al. 2006); the need for respect; common goals and agreed objectives and transparent lines of communication between partners; blurring of professional boundaries, teamwork and joint working (Robinson and Cottrel, 2005). While much of the literature considers partnerships between professionals, Bidmead and Cowley (2005) conducted a concept analysis of partnership with health visiting clients and arrived at 11 attributes of partnership: genuine and trusting relationship; honest and open communication and listening; praise and encouragement; reciprocity; empathy; sharing and respect for the others' expertise; working together with negotiation of goals, plans and boundaries; participation and involvement; support and advocacy; information giving; and enabling choice and equity. It seems evident then, that partnership between professionals and clients includes some additional attributes not normally associated with partnership between professionals such as praise and encouragement, support and advocacy, and enabling choice and equity.

Defining attributes can therefore be summarized as follows:

- Trust and confidence in accountability
- Respect for specialist expertise
- Joint working
- Teamwork
- Blurring of professional boundaries
- Members of partnerships share the same vested interests
- Appropriate governance structures
- Common goals
- Transparent lines of communication within and between partner agencies
- Agreement about objectives
- Reciprocity
- Empathy

We can see that the trust and respect evident between partners has a substantive ethical content. What this amounts to is that partners really need to have a shared identity. As Robinson and Cottrel's (2005) research shows, role convergence can occur in multi-disciplinary partnerships in which members become affiliated to the team rather than to different agencies. However, as Robinson and Cottrel point out, while this has advantages for teamwork, it can cause concern over threats to specialist identity.

This may mean the gradual erosion of current professional identities in favour of new, more problem orientated professional partnerships or even, professions. The

potential threat to professional identity may lead to a reluctance to collaborate, as it could be perceived as threatening existing professional boundaries or failing to develop a particular profession (Masterson 2002). Indeed, one could argue that an ideal partnership would be practically impossible, as partnerships need at least two clearly identifiable partners. In the long-term this may happen but at this transitional stage in health and social care provision, partnerships may represent a staging post. Trade union reform in recent years has seen the amalgamation of smaller unions who initially formed partnerships with other similarly related unions. While starting off as partners, these reconstituted unions such as UNISON took on a new single identity. Over time the sense that this union was a partnership of smaller unions has been forgotten. Therefore there are limits to what can really be called a partnership. There must be some tension in all partnerships between different partners' identities and all partners' commitment to a shared identity. What determines differences between partnership models is less a shared commitment and more the nature of each partnership's commitment. Types of partnership can be differentiated by the type of commitment they undertake, which we summarize as follows.

Project partnership

These are partnerships that are time limited for the duration of a particular project. A partnership between the police and other road safety organizations to lower the speed limit will end when their project is successful. Equally, when two companies sign a joint contract to manufacture a particular product, the partnership ends when production ceases. In Chapter 13, for example, a multi-agency 'project partnership' funded by the Welsh Assembly Government is described, which aimed to redress the inequality of access to health care experienced by the Traveller population in North East Wales. Arguably, once the funding ceases and the aims have been achieved, then the partnership could cease to exist.

Problem oriented partnerships

These are partnerships that are formed to meet specific problems. Examples of this might include Neighbourhood Watch schemes or substance abuse teams. These partnerships arise in response to a publicly identified problem and remain as long as the problem persists. These can be subject to changing definitions of what the 'problem' really is. Chapter 14, for example, discusses a partnership group established in Leeds to develop a strategic multi-agency approach to provide services for mentally disordered offenders. It can be defined as a problem orientated partnership because it arose from a recognition that people with mental health problems who offend were not always dealt with appropriately, and a belief that a partnership response was the most effective way of addressing the issues.

Ideological partnerships

These types of partnerships arise from a shared outlook or point of view. They are similar in many ways to problem oriented partnerships, but they also possess a certain

viewpoint that they are convinced is the correct way of seeing things. A case in point is abortion in which various organizations, ideologically aligned, form a 'pro-life' and a 'pro-choice' partnership. In addition, various anti-war and peace partnerships are ideologically driven. As with problem oriented partnerships, ideology can change and develop. For instance, Amnesty International or Christian Aid have evolved into more overt political partnerships as the ideological context has widened. Within this book, this type of partnership is illustrated in the Coventry Domestic Violence Partnership, established in the 1980s as a focus group to advise planners and commissioners in health and social care about service gaps and priorities (see Chapter 12). Although the impetus for the partnership came from the voluntary sector in collaboration with the police and 'safer cities' community safety workers, it has since developed into a strong and dynamic multi-agency partnership with a wide remit across the spectrum of public and community services. Although, as suggested above, this could be described as a problem oriented partnership, its long-term dynamic nature is suggestive of an ideological partnership.

Ethical partnerships

These share a number of features with the above but they also have a sense of 'mission' and have an overtly ethical agenda, that seeks to promote a particular way of life. They tend to be democratic and reflective and are as equally focused on the means as the end. While most partnerships have codes of ethics or ethical procedures, ethical partnerships have a substantive ethical content in their mission and practice.

The above types of partnerships are inclusive; indeed some partnerships might have all of the above types within it. For instance, it would be reasonable to conclude that health and social care partnerships are ethical partnerships since they aim at helping people. However, they may also work successfully but be ideologically distinct. Social services, for example, may favour a 'social model' approach, while the health care system may favour a more 'medicalized' approach. Project partnerships may take a problem oriented approach to their work at the behest of one of the partners. Service users may want particular problems solved and demand that service providers address ongoing issues rather than focusing on the big picture.

Gallant et al. (2002) also suggest that partnership attributes include *structure* and *process* phenomenon. The *structure* involves partners in two phases in their relationship – initiating and working phases (Courtney et al. 1996). During the initiating phase, they negotiate responsibilities and actions, while during the working phase they evaluate their progress towards the goal of partnership. The structure might also include identification of suitable partners. Most literature relating to partnership identifies partnership arrangements between certain groups, including both service providers and service users. An example of this is Roberts' (2002) study, which found that older people welcome advice concerning their discharge from hospital and during the period following discharge, although some preferred decisions to be made for them. Roberts used Arnstein's ladder of citizen participation (discussed further in Chapter 3) to analyse the findings, with notions of 'partnership', 'relationship', 'communication' and 'paternalism' being discussed. As will be seen in the chapters of this book, however, involving vulnerable people in partnership can be difficult, when

there is still so much work to do in developing multi-agency partnerships. As can be seen in Chapter 14, for example, 'involving service users in forensic mental health poses a challenge because some individuals present a significant risk and are difficult to engage and treat'.

Key to the *process* of partnership is the involvement of partners in power sharing and negotiation (Gallant et al. 2002). In partnerships between health and social care agencies, this process might involve considerable negotiation in order to arrive at a shared understanding of roles and responsibilities across multi-disciplinary boundaries, as well as the relinquishing of power relationships. Equally in partnerships between clients and professionals, this same process of negotiation and relinquishing of professional power will take place. However, this can be difficult in practice, particularly if professional codes of practice and legal frameworks work against it. In addition, there are safety issues that, while they might help the effective management of a partnership, may restrict the scope of practice. While it might be practically better for a social worker to assess clients' health needs, professionally it might be difficult for a nurse to give care solely on the basis of this assessment. Professional rules may insist on nurses carrying out their own assessments.

Attributes of collaboration

The defining attributes of collaboration include that 'two or more individuals must be involved in a joint venture, typically one of an intellectual nature in which participants willingly participate in planning and decision making' (Henneman et al. 1995: 104). Henneman et al. further argue that individuals consider themselves to be members of a team working towards a common goal, sharing their expertise and responsibility for the outcome. Fundamentally, the relationship between collaborators is nonhierarchical, and shared power is based on knowledge and expertise, rather than role or title (Henneman et al. 1995). Similarly, Hudson et al. (1998) emphasize joint working as a key characteristic of collaboration, and add that trust and respect for partners means that they are willing to participate in formal, structured joint working, including joint assessments, planning, service delivery and commissioning. Interestingly, Hudson et al. (1998) place collaboration on a continuum from isolation (in which there is an absence of joint activity) through to integration (in which separate identities are no longer significant and the creation of unitary organization may be possible) (see Figure 1.1).

More recently, in a literature review of collaboration, D'Amour et al. (2005) found that certain concepts were mentioned repeatedly in the definitions of collaboration, which included: sharing, partnership, and interdependency.

The defining attributes of collaboration can therefore be summarized as follows:

- Intellectual and cooperative endeavor
- Knowledge and expertise more important than role or title
- Joint venture
- Team working
- Participation in planning and decision making

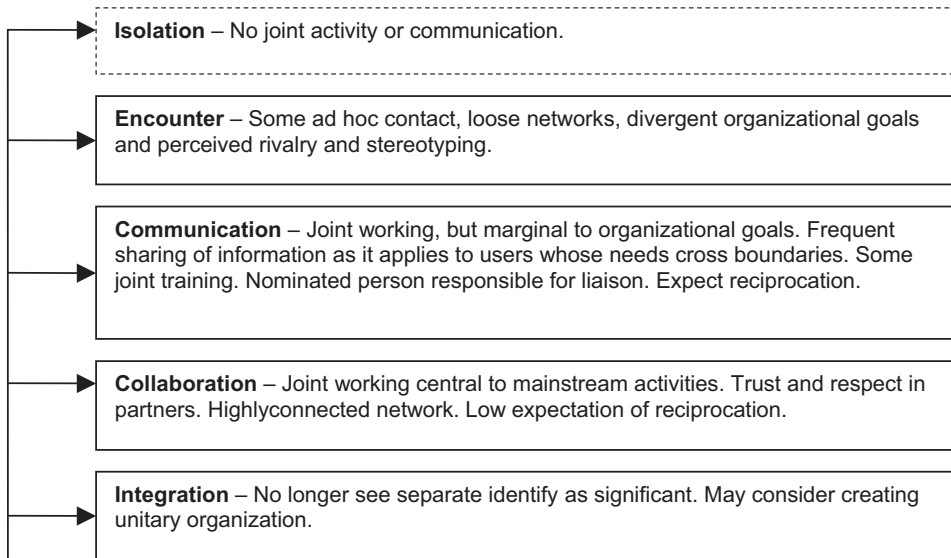


Figure 1.1 Characteristics of collaboration

Source: Hudson et al. 1998

- Nonhierarchical relationship
- Sharing of expertise
- Willingness to work together towards an agreed purpose
- Trust and respect in collaborators
- Partnership
- Inter-dependency
- Highly connected network
- Low expectation of reciprocation

As in the concept of partnership, the involvement of the public is central to working collaboratively. Stewart and Reutter (2001) exemplify this, citing evidence from three studies in which peers and professionals collaborated as co-leaders and partners in 21 support groups. The three studies were: survivors of myocardial infarction and their spouses; parents of children with chronic conditions; and older women with disabilities. These three studies, however, are all contextualized around chronic illness, which might not be universally applicable. The current consensus of opinion, for example, is that clients with chronic illnesses have more insight into their conditions than professionals do. Indeed, it is significant that many examples cited in the literature deal with chronic problems such as social care, disabilities and mental health.

Identifying 'model', 'related' and 'contrary' cases of partnership and collaboration

Having refined the concepts through identifying their defining attributes, the next stage of analysing concepts is to identify a 'model' case, a 'related' case and a 'contrary' case (Walker and Avant 1995). A model case includes all the stated attributes of the concept and is so called because there is no doubt that it represents the concept. Clifford (2003) suggests the model case of 'partnership' between education and service providers would be people (or organizations) willing to join with a partner, together with a shared vision and commitment to making the partnership work. Clifford also remarks that collaborative arrangements would be set up to demonstrate a willingness to share in successes and failures. An example of a model case can also be seen in the Partnerships for Carers in Suffolk (Chapter 7). This could be described as a model case because each partner 'signed up' for the Charter for Carers in Suffolk, and furthermore, each of the partners is committed to implementing an action plan. However, to be certain that this was a model case we would need to have more intimate insights into the initiative and compare its characteristics with the defining attributes listed above to see if they were all present.

A model case of collaboration would occur if a social services department joined with a local NHS trust to identify training needs of their staff, and used knowledge and expertise from both partners to produce shared training. If they also had mutual respect and trust, with strong networks, together with joint working, planning and service delivery, this would be a good example of a model case. In this instance, it seems that collaboration is a means of making 'partnership' work. That is, 'collaboration', the verb, is what we do when we engage successfully in a 'partnership', partnership being the noun. Considering Hudson et al.'s (1998) continuum in more detail, there would be few examples of 'isolation' in health and social care agencies, as this would suggest that they never met, wrote to or talked to each other. 'Encounters' in health and social care agencies would imply infrequent, ad hoc, inter-professional contact, characterized by rivalry and stereotyping. While it may be assumed that in modern health and social care agencies, such 'encounters' would be rare, professionals do stereotype other professional groups and make assumptions about what they expect from them, which can limit the effectiveness of collaboration. This can be seen in Chapter 8, when a person's drug problem can be interpreted very differently by different agencies with different treatment options proposed as a consequence. Stereotyping can also exist when dealing with homelessness, when, as discussed in Chapter 9, social services staff are frequently perceived by the voluntary sector as being aloof, unapproachable and not fulfilling their statutory responsibilities. They in turn complain that voluntary sector staff do not understand the limits of those responsibilities and fail to appreciate what they can take on within the parameters of their departments and their scarce resources. Modern health and social care agencies are arguably in transition from communication to collaboration. However, the high degree of trust and low expectation of reciprocation within collaboration might suggest that many health and social care agencies still have considerable progress to make.

Identifying a related case of these terms (Walker and Avant 1995) is a little more difficult, as this requires a similar (but different) instance of partnership or collaboration to be identified. A related case for 'partnership' could be an 'associate partner', as this implies a connection between two organizations or people, but the link would be quite loose and might imply that one of the organisations or people was subordinate to the other. An example of this would be an associate director, who would normally act as deputy to the director. At the level of patient/client partnership, Cahill (1996) presents a concept analysis of *patient participation* and suggests that patient *partnership* is a related case for this concept, along with patient *collaboration* and patient *involvement*. She views patient involvement and collaboration as being at the bottom of a pyramid. Slightly higher up the pyramid is patient participation, while at the top is partnership, this being the goal to which all practitioners should aspire. This suggests then that as people become more involved, they begin to collaborate with each other and through this process of collaboration a greater sense of involvement transpires. This sense of involvement can ultimately result in sufficient trust, respect and willingness on the part of different parties for partnership to develop (see Figure 1.2).

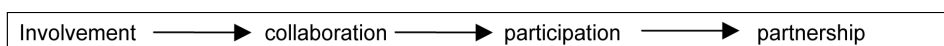


Figure 1.2 A continuum of involvement

A related case of 'collaboration' could be an 'alliance' in which organizations share some understanding, but may lack the joint working arrangements required to be collaborators.

Identifying a 'contrary' case is even more difficult, for the contrary case must have characteristics that illustrate that it is not representative of the concept, although similarities may be present. A contrary case of 'partnership' would be when two organizations or people convey the impression of being partners when in fact the characteristics they display do not resemble those of a true partnership. We see examples of this with many professional sports personalities. Some professional footballers are accused of not being a 'team player' and some nurses and social workers are accused of the same thing when they do 'their own thing'.

A contrary case of collaboration could be seen in organizations that communicate (Hudson et al. 1998) with each other, but only as far as they need to in order to deliver services across organizational boundaries. Frequent liaison may give the impression of collaboration when in fact the expectation of reciprocation may reveal a different state of affairs. This is currently the norm in many areas, where services communicate on a case by case basis. An example of this can be seen in child protection work in which the child protection system is complex with a bewildering overlap of occupational boundaries and the added complication of disadvantaged and transient families (Chapter 5). With such complexity it is not surprising that collaborative working between different professional groups is difficult. Another example is illustrated in mental health work in which psychiatric team members complain that they are not on the same level as other members of the team, or that

they use a different professional language compared to other team members, which enables them to shore up a separate professional identity (Hamilton et al. 2004; see also Chapter 6).

Antecedents and consequences of partnership and collaboration

Walker and Avant (1995) also suggest that concepts have antecedents and consequences, some examples of which can be seen in Table 1.1. Antecedents are events that happen prior to the concept occurring, while consequences follow the occurrence of the concept. According to Walker and Avant, exploring antecedents and consequences enables us to refine the attributes of the concept. So, for partnerships to occur in health and social care, certain events must happen first. These might include local directives, individual initiatives and social policy changes; and they can occur at all levels in the organization and may spring up in response to individual, local or national perceptions. Doran (2001), for instance, traces the route from policy to practice in the proposed integration of district nursing services with social services to provide a seamless care in the community. Another example of policy antecedents is the legislation concerning paedophilia, which arose from a bereaved mother's suffering as a result of her daughter's murder. Partnerships between parents with autistic children and research centres grew out a 'perceived' increase in cases of autism. In many ways, their antecedents define partnerships. In response to antecedents, for 'partnership' to occur, there must be two sides who are committed to a shared vision about the joint venture, and there must be two or more people who are willing to sign up to creating a relationship that will support this (Clifford 2003). Furthermore, partners must respect what other partners bring to the relationship (Labonte 1994).

According to Henneman et al. (1995), antecedents to collaboration include a number of personnel and environmental factors (see Table 1.1). Personnel factors include: sufficient educational preparation, maturity and experience to ensure readiness to engage in collaboration; clear understanding and acceptance of their role and expertise; confidence in ability and recognition of disciplinary boundaries; effective communication, respect for and understanding of others' roles; sharing of knowledge, values, responsibility, visions and outcomes; and trust in collaborators. Environmental factors include: a nonhierarchical organization in which individuals can act autonomously and in which reward systems recognize group rather than individual achievements. Furthermore, they must be willing to participate in formal, structured joint working to the extent that they do not rely on reciprocation in order to ensure that each contributes to the shared vision (Hudson et al. 1998).

The consequences of 'partnership' can result in benefits, but there are also some barriers to working in partnership. The main benefits of working in partnership are that multi-faceted problems, such as social exclusion, can be tackled more effectively through multi-disciplinary action (Peckham and Exworthy 2003). For example, partnership working can reduce repetition of service provision from different organi-

zations. It can also ensure that services are not withdrawn by one service because of the mistaken belief that another organization is providing them. Another consequence of partnership is that it can prevent dilution of activities by agencies as they each try to deliver services independently of each other. Finally, it can reduce the possibility of different agencies producing services that are counterproductive to each other.

Barriers to working in partnership have also been reported in the literature. Barriers can exist at a healthcare system level or at the individual client level. The English healthcare system, for example, creates barriers between health and social care, partly through government guidance reinforcing dominance of the biomedical model, but also through quasi-markets in healthcare, which also sustain the health- and social care divide (McMurray 2006). Another barrier at the healthcare system level is the complexity of relationships due to the greater interplay between those involved in the partnership (Gallant et al. 2002), an example of this being collaboration to protect children as discussed above in relation to Corby et al.'s chapter. At the individual level, Burke (2001) cautions that there is some scepticism about the partnership approach with respect to a number of factors, including how much particular individuals can be representative of the wider public; concern that public participation can lead to both tokenism and to excessive influence of vocal groups, and the possibility that individuals might not wish to be involved in making decisions about their care.

Secker and Hill (2001) also report a number of barriers arising in mental health services. One important barrier was a reluctance to share information about clients due to confidentiality, which, if breached, could result in staff dealing with unanticipated responses from clients with inadequate knowledge and support. This could also be a problem when partnership involves the joint use or joint commissioning of premises in rural areas, where even the simple act of going into a particular building may be witnessed by others and may lead to particular assumptions about what is going on. Working with people who are HIV positive is one example of this, as they may be reluctant to fill in prescriptions in their home neighbourhood and often hide or relabel medications to maintain secrecy within the home (see Chapter 15).

Role boundary conflicts and tensions between agencies were also reported as barriers in Secker and Hill's (2001) study, such that both learning disability nurses and the police service felt that they were 'dumped on' by mental health services. Such boundary conflicts were reported to arise partly from inadequate resourcing of mental health services, as well as misunderstanding of agency roles, often resulting in unrealistic expectations. Other barriers to partnership included inter-professional differences of perspective (such as those arising from the medical model and the more holistic social model) and differences in approach to risk. As a number of authors have suggested, as multi-disciplinary working gains momentum and professional roles converge, the more professional identities are threatened (Robinson and Cottrel 2005), to the extent that professionals will either be reluctant to collaborate (Masterson 2002) or will use their own professional language in furtherance of their separate identity (Hamilton et al. 2004).

The consequences of *collaboration* can also be explained in terms of benefits and barriers. The benefits of collaboration include: more effective use of staff as they utilise their skills cooperatively rather than competitively (Henneman et al. 1995), demystification of health care with the bridging of gaps between fragmented service provision, sustained energy, cross-pollination of ideas, sharing of effort and ultimately sharing of organizational structure (El Ansari and Phillips 2001). There are also a number of barriers to closer collaboration. These may include a fear that individual professions may be threatened as work becomes more problem focused (Billingsley and Lang 2002). Brown et al. (2000) suggest that a lack of managerial direction and the encouragement of a more generic way of working can prevent closer collaboration across professional boundaries. In collaboration between service providers and service users, service users may be reluctant to assume an equal part in partnerships. Roberts' (2002) study of older people on discharge showed that some preferred service providers to make decisions for them. However, this may reflect older people's perspectives on the relationship between professionals and patients. Likewise, as indicated in Chapter 9, homeless clients may have their own preferences about which needs should be addressed first, and problems can arise if the priorities of clients are at odds with the priorities of staff.

A summary of the defining attributes, antecedents and consequences of partnership and collaboration is presented in Table 1.1

As indicated in Table 1.1 there are a number of similarities between the concepts of partnership and collaboration. Within their defining attributes each share traits of trust and respect for partners, joint working and teamwork. The main shared antecedent is a willingness to participate; while the main shared consequence is increased effectiveness of staff resources.

The final stage in Walker and Avant's (1995) concept analysis framework is to identify empirical referents to the concept. These provide examples of the concept in practice, so that the concept can be measured and validated in order to demonstrate that it does actually exist. For example, observing procedures, processes and the behaviour of people within organizations would show evidence of partnership and collaboration. A partnership, for example, might be legally binding with a written contract detailing the obligations of each partner. A collaboration could be evidenced by written procedures for joint working. These could then be checked through observation and/or participation to establish the extent of collaboration. Throughout this chapter there are many examples of how partnership and collaboration are played out in the behaviour of personnel and all of these can provide evidence that partnership and collaboration really do exist.

Conclusion

This chapter has explored and analysed the concepts of partnership and collaboration. Partnerships, collaboration and working together need to be seen as new solutions to 'new' problems. It may be the case that the current situation reflects both a negative view of the paternalistic state with its grand narratives of fairness and equality, and a more positive view that wants to put the client at the centre of things.

Whatever the reason, and we suspect that both have played their part, partnerships and collaboration are likely to grow rather than diminish. Evidence discussed above suggests that, despite the potential barriers to partnership and collaboration, they are worthwhile pursuits. Moreover, policy directives are creating the imperative for organizations to work together. However, the evidence for the effectiveness of partnerships and collaborative care arrangements are less clear (El Ansari and Phillips 2001).

This may indicate that the current view is more that partnerships and collaboration are good in themselves, rather than more effective at solving problems. However, there is no doubt that client problems are more complex and require new ways of working. Part of the reason for the paucity of evidence about their effectiveness may be that they need time to be integrated with existing provision. In addition, if partnerships and collaboration are going to be the future ways of working together, old forms of professional education and training need to be reviewed. The problem with new innovative ways of working may be that they are working within the old context, where professions were discrete entities with their own body of knowledge. So while the policy context is changing to encourage collaboration and partnerships, professional regulation has been slow to catch up. In addition, many clients and potential clients still prefer the old ways of working and may be reluctant to become too involved in their care. What seems clear, however, is that certain problems will, by their nature, be more amenable to a partnership or collaborative approach.

Questions for further discussion

- 1 What attributes of partnership and collaboration have you found in health and social care settings evidence?
- 2 What benefits (if any) of partnership and collaboration do you think exist in health and social care settings?
- 3 How can the barriers to partnership and collaboration be overcome?