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Understanding partnerships 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 examine 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

Literature in health and social care is replete with synonyms referring to the need for health and social care agencies to ‘work together’ more effectively in ‘partnership’ and in ‘collaboration’. These words are frequently used interchangeably, often within the same paragraph or even sentence. Much of the use of terminology is policy driven, promoting terms such as ‘joined-up thinking’ and ‘joined-up working’, so that services can be delivered ‘seamlessly’ (NHS Executive 1998).

As a preliminary, we think it worthwhile to distinguish broadly between what something is, that is a partnership, and what one does, that is collaborate or work together. This chapter will initially identify the different models of partnership currently in use, and then look at the way these different partnerships actually operate. 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 little more than rhetoric or an end in itself, with limited evidence that theoretical 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 partnerships are in practice. However, before doing this, it is important to consider 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 (Carter 1998). Philosophically and 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 (1992) 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 fifty years. Lyotard sees these attempts at ameliorating social problems 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. Since the 1980s, both the system and professionals within the system in Britain have largely been seen as disempowering for clients and receivers of services, with the emergence of terms such as ‘nanny state’ or ‘disabling state’. These critiques have in part resulted in an increasing emphasis on client or ‘consumer’ choice. Health and social care services have been encouraged to allow consumers to become more involved and to have more say in the design and provision of services. Part of the reason for this refocusing on clients as active consumers rather than passive recipients of services may simply be that health and social problems have become more complex and multidimensional 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 have reacted to the rise in ‘social’ problems. This is increasingly seen as too simplistic a way of tackling more difficult and intractable problems. For example, there is, undoubtedly, a close relationship between illness and poverty.

It is in the context of putting clients at the centre of health and social care that partnerships have become necessary. The complexity of client problems, requiring an input from a number of services, may be more important in designing services than the traditional, centralizing distinctions between, for example, social workers and community nurses. A community may have a need or problem that is peculiar to that particular area or community. For instance, Bournemouth may have greater need of specialized care for older people than other areas. A client 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 clients’ needs. People’s needs may change over time and place and so partnerships may be formed to meet particular problems.

However, while most people would agree that clients should participate and be involved in the choices that affect their lives, some practical implications need to be
considered. The shift is likely to lead to a ‘problem-oriented’ approach to health and social care and the disappearance of discrete professions such as nursing and social work. With the emphasis of social care and health changing to meet local needs through local solutions, the rationale for 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 from a range of authors concerning problem-specific partnerships focusing upon areas as diverse as Gypsy Travellers, victims of domestic violence and drug users, to name but a few, but what is evident from their writing is that they can demonstrate explicit examples of partnerships in practice. 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 in the book, this chapter will:

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

Partnerships and collaboration: what are they?

The concept of partnership

The concept analysis framework identified by Walker and Avant (1995) requires that definitions of the terms are first sought, including dictionary definitions and those used within the literature. Subjecting the concepts of ‘partnership’ and ‘collaboration’ to this process reveals some interesting similarities and differences between them. Dictionary definitions of the term ‘partnership’ are in Box 1.1 and Table 1.2.

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**Box 1.1 Definitions of partnership**

*Collins English Dictionary* (1991)
- Equal commitment
- The state of being a partner

- 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
The reference to business partnerships is interesting given the recent trends in health and social care towards contracting out service delivery. Use of the term ‘partnership’ in health and social care settings is profoundly influenced by policy, which is frequently subject to change.

In analysing the concept of partnership as it applies to health and social care, it is useful to consider Rodgers’s (2000) concept analysis framework as this takes into account the ‘context’ of the concept (Gallant et al. 2002). Context is important in defining terms like partnership and collaboration, because both terms have changed in use across time and place. This is illustrated by Gallant et al. (2002), who points out that ‘partnership’ has changed over the past five decades, from an emphasis on an equitable, just and free society enshrined within the International Declaration of Human Rights (United Nations 1948), through the need to enable citizens to become more self-reliant and take control over their own health (WHO 1978), to contemporary commentators, such as Frankel (1994), who point out 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 6 of this book, which traces his experiences of accessing health, social and educational services during the past 40 years.

This need for both public involvement and partnerships between service providers is reflected in recent policies, such as the New NHS Modern Dependable (DoH 1997), Modernising Health and Social Services: Developing the Workforce (DoH 1999a) and the Health Act (1999). Indeed, the Health Act demands that health and social services departments must reach planning agreements, and these must identify which services are to be provided by each agency, and how individuals will be assessed. Modernising Health and Social Services goes further, in encouraging joint education and employment and deployment of staff, in order to meet the needs of the local population. In addition, The NHS Executive (1998) recommended community development as a means of solving local problems in partnership with statutory agencies. In 2000, A Health Service of All the Talents: Developing the NHS Workforce (DoH 2000) also stressed concepts of partnership and collaboration with its emphasis on teamwork across professional boundaries, eliminating boundaries which dictate that only doctors and nurses can provide certain types of care, and developing flexible careers. Although Parrott presents a detailed account of the politics of partnership in Chapter 2, we can conclude here that current policy emphasizes ‘three-way partnerships’ 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 a partnership is 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 actually 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 imply that all parties to 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. Allison takes up this very point in Chapter 3 when she discusses 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 1.2.

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<th>Box 1.2 Dictionary definitions of collaboration</th>
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<tr>
<td>• Co-operate traitorously with an enemy</td>
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<tr>
<td>• Work jointly</td>
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These two very different definitions perhaps reflect the change of emphasis in health and social care over recent decades. Hence, the need to consider the context of the concept (Rodgers 2002) 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 health and social care professions, to the extent that working together would have been regarded as problematic. However, recent policy reforms illustrated in this book within numerous chapters (see, for example, Wyner Chapter 9 or Minoghue Chapter 14) have encouraged different professional groups to break down barriers and 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’. In fact, Burke (2001) cites Service Level Agreements (SLAs) as an example of how agencies have been encouraged to work together by the government. Here, it is suggested that both purchasers of health care and the NHS trusts that provide care should draw up SLAs lasting 3–10 years, which should be based on health improvement programmes. Health improvement programmes are also drawn up by different agencies working together (Burke 2001).

Defining 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 1.2). Derived from the literature, these defining attributes identify specific phenomena and assist in
differentiation from other similar concepts. In this case, the process will help to
differentiate between the concepts of ‘partnership’ (who we are) and ‘collaboration’
(what we do).

Attributes of partnership

Defining attributes that emerged in the literature in relation to partnership are:

- Trust in partners
- Respect for partners
- Joint working
- Teamwork
- Eliminating boundaries
- Being an ally

These attributes illustrate the shared commitment that characterizes partnership and
show that it has a substantive ethical content. All partners need to have trust in and
respect for other partners. What this amounts to is that partners really need to have a
shared identity. As Hudson et al.’s (1998) work shows, the key characteristic of part-
nerships is integration, where partners no longer see their separate identities as signifi-
cant. This means that part of this shared commitment is a shared identity. However,
this could lead to a lessening of a long-standing commitment to a previous, separate
identity. As has already been indicated, this may mean the gradual erosion of current
professional identities in favour of new, more problem-orientated professional
partnerships or even, professions. This has led to difficulties with some potential
partners feeling that their individual identity is under threat. This may lead to a failure
to collaborate as often, 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 partner-
ships 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. Take, for example, trade union reform in recent years, which
has seen the amalgamation of many 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 will inevitably be some tension
in partnerships between different partners’ identities and all partners’ commitment to
a shared identity. What determines differences between partnership models is less a
shared commitment but more the nature of each partnership’s commitment. Types
of partnership can be differentiated by the type of commitment they undertake,
summarized as:

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 organ-
izations to lower the speed limit may end when their project is successful. Equally,
when two companies sign a joint contract to manufacture a particular product, the partnership may end when production ceases. In Chapter 7, Roberts describes a multi-agency ‘project partnership’ funded by the Welsh Assembly Government, which aims to describe the coronary health status and 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 Drug and Alcohol Action Teams. These partnerships arise in response to a publicly identified problem and will remain as long as the problem persists. These can be subject to changing definitions of what the ‘problem’ really is. An example of this can be seen in Minogue’s discussion in Chapter 14 of 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’ or a ‘pro-choice’ partnership. Another example is the various anti-war and peace partnerships. 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 Chapter 8, when Blyth describes 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. 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-orientated 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, which 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 to help people. However, they may also work successfully but be ideologically distinct. Social services 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 the actions of the initiating and working phases within their relationship (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’s study (2002), 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 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. Moreland et al. illustrate this point in Chapter 16, when they explain how some community capacity building has been carried out in the ‘Twice A Child Projects’. This involves empowering social groups to participate in decision making, which requires skills of involvement and persuasion, as well as the ability to articulate persuasively the needs of the group. They suggest that this limited development of community capacity is due to local political and ideological realities, allied to real issues over current authority policies and practices on service planning, staffing, redundancy and redeployment.

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 multidisciplinary 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 practically be 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 non-hierarchical, and shared power is based on knowledge and expertise, rather than role or title (Henneman et al. 1995).

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

- Intellectual and co-operative endeavour
- Knowledge and expertise more important than role or title
- Joint venture
- Teamworking
- Participation in planning and decision making
- Non-hierarchical relationship
- Sharing of expertise
- Willingness to work together towards an agreed purpose
- Trust and respect in collaborators
- 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 should be set up to demonstrate a willingness to share in successes and failures. An example of a model case can also be seen in Chapter 15, when Chambers and Philips refer to the ‘Partnerships for Carers in Suffolk’. 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.

In identifying a model case of ‘collaboration’ it is useful to consider Hudson et al.’s (1998) view of a continuum from isolation, through encounter, communication and collaboration, to integration. The characteristics evident within this continuum are identified in Table 1.1.

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. 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. A model case of collaboration would, therefore, comprise the characteristics identified by Hudson et al. (1998), such as trust and respect between collaborators, together with joint working, planning and service delivery. This example of a model case would also include all the attributes of collaboration listed in the previous section. There would be few examples of isolation in health and social care agencies, as this would suggest that they never met, contacted 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, Buchanan and Corby’s research in Chapter 11 concerning work with drug-using parents would suggest otherwise. The professionals they interviewed about their role in drug misuse felt that although collaboration was important, it was difficult to

Table 1.1 Characteristics of collaboration (Hudson et al. 1998)

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Description</th>
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<tbody>
<tr>
<td>Isolation</td>
<td>Absence of joint activity with no communication at all between agencies.</td>
</tr>
<tr>
<td>Encounter</td>
<td>Some ad hoc inter-agency contact, but lowly connected networks, divergent organizational goals and perceived rivalry and stereotyping.</td>
</tr>
<tr>
<td>Communication</td>
<td>Joint working, but marginal to organizational goals. Frequent interactions and sharing of information as it applies to users whose needs cross boundaries, some joint training, a nominated person is responsible for liaison, expectation of reciprocation.</td>
</tr>
<tr>
<td>Collaboration</td>
<td>Joint working is central to mainstream activities. Trust and respect in partners means that they are willing to participate in formal, structured joint working including joint assessments, planning, service delivery and commissioning. There is a highly connected network and low expectation of reciprocation.</td>
</tr>
<tr>
<td>Integration</td>
<td>No longer see their separate identify as significant. May be willing to consider creation of unitary organization.</td>
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achieve due to other professionals being either ill-informed and ill-trained in relation to illegal drug use, or insufficiently discerning in the way in which they worked with drug-using parents. Stereotyping is also evident in Wyner’s discussion of homelessness in Chapter 9. She explains how 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 social services 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 health and social care agencies 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 ‘associate’, as this implies a connection between two organizations or people, but the link would be quite loose and might imply that one of the organizations 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, being precursors to patient participation, which in turn is a precursor to patient partnership. Cahill (1996) goes on to argue that partnership is a 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 1.1).

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 which 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 in so far as they need to in order to

![Figure 1.1: A continuum of involvement](image-url)
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 Chapter 6 when Corby explains how inter-professional training has been variable over the past decade, according to the post-Climbie audit. He goes on to suggest that the child protection system is complex with a bewildering overlap of occupational boundaries and the added complication of disadvantaged and transient families. With such complexity it is not surprising that collaborative working between different professional groups is difficult. Another example is cited by Miller in Chapter 13, in relation to teachers and youth workers. Miller argues that although there is some collaboration between the two, for many teachers and youth workers, there still exists a perceived distance in terms of practice and often a mutually critical attitude towards each other’s style of engagement with young people.

Antecedents and consequences

Walker and Avant (1995) also suggest that concepts have antecedents and consequences, some examples of which can be seen in Table 1.2. 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 facilitates further refinement of the defining attributes of the concept. Antecedents for partnerships include local directives, individual initiative and social policy changes. Antecedents can occur at all levels and may spring up in response to individual, local and 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 recent 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 of 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 value co-operation (Courtney 1995) and 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, rather than merely the willingness of one party to work jointly with the other (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 other’s roles; sharing of knowledge, values, responsibility, visions and outcomes; trust in collaborators. Environmental factors include: a non-hierarchical organization in which individuals
can act autonomously and in which reward systems recognize group rather than individual achievements. Furthermore, the parties 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 be understood in terms of the benefits and 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 multidisciplinary action (Peckham and Exworthy 2003). This would then reduce repetition of service provision from different organizations; the omission of provision of services because each organization believes the other is providing them; unnecessary dilution of activities by agencies as they each try to deliver services; and the possibility of different agencies producing services that are counterproductive to each other. These are what Huxham and MacDonald (1992) refer to as the pitfalls of individualism. However, some see this loss of individualism as a barrier to partnerships. In a recent study, Masterson (2002) saw cross-boundary working as a possible barrier to the development of new professional roles in nursing.

Barriers to working in partnership have also been reported in the literature. One barrier could be 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’s chapter. 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 (as exemplified in Moreland et al.’s chapter) 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 from group discussions with 128 participants from 21 organizations working across five service contexts dealing with 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 presumptions about what is going on (Pugh, Chapter 5). Wilson supports this view in Chapter 10, when she explains how people who are HIV positive may be reluctant to fill in prescriptions in their home neighbourhood and often hide or relabel medications to maintain secrecy within the home.

Role boundary conflicts and tensions between agencies were also reported as barriers in Secker and Hill’s study (2001), 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 interprofessional differences of perspective (such as those arising from the medical model and the more holistic social model) and differences in approach to risk. As multidisciplinary working becomes more prevalent, blurring of roles may cause some professionals...
to strive to preserve their own professional identity (Brown et al. 2000). Indeed Brown et al. argue that boundaries between professions are actively encouraged by the experience of interdisciplinary modes of working. In addition, Gulliver et al. (2002) point out some of the legal barriers to closer integration. As well as legal barriers, there may be professional issues of accountability that need to be clearly defined if they are not to become barriers to effective partnerships. In overcoming some of the barriers to collaboration and partnership it may is useful to consider Bates’s suggestion in Chapter 4. He proposes four strategies by which health and social care professionals can move forward in a way that embraces diversity: learn from each other; embrace partnership; adopt a value position where anti-discriminatory practice is central; and reflect on practice.

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 utilize their skills co-operatively 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. This may include a fear that individual professions may be threatened as work becomes more problem-focused (Billingsley and Lang 2002). Brown et al. (2000) explain how 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 role in partnerships. Roberts’s 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.

A summary of the defining attributes, antecedents and consequences of partnership and collaboration is presented in Table 1.2.

As indicated in Table 1.2, 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. It is interesting that the concept of collaboration has more defining features than does the concept of partnership. This might suggest a more complex concept, which, once achieved, might result in the proliferation of potential partnerships.

The final stage in Walker and Avant’s (1995) concept analysis framework is to identify empirical referents to the concept. Empirical referents of partnership and collaboration would be evidenced from behaviour within organizations and people who could be observed. These exemplify the existence of the concept, so that the concept can be measured and validated in order to demonstrate its true existence. 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. Examples of these as they appear in this book are discussed above.
Table 1.2 Attributes, antecedents and consequences of partnership and collaboration

<table>
<thead>
<tr>
<th>Defining attributes</th>
<th>Partnership</th>
<th>Collaboration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trust in partners</td>
<td>Trust in partners</td>
<td>Trust and respect in collaborators</td>
</tr>
<tr>
<td>Respect for partners</td>
<td>Respect for partners</td>
<td>Teamworking</td>
</tr>
<tr>
<td>Joint working</td>
<td>Joint working</td>
<td>Intellectual and co-operative endeavour</td>
</tr>
<tr>
<td>Teamwork</td>
<td>Teamwork</td>
<td>Knowledge and expertise more important than role or title</td>
</tr>
<tr>
<td>Eliminating boundaries</td>
<td>Eliminating boundaries</td>
<td>Joint venture</td>
</tr>
<tr>
<td>Being an ally</td>
<td>Being an ally</td>
<td>Participation in planning and decision making</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Non-hierarchical relationship</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Sharing of expertise</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Willingness to work together</td>
</tr>
<tr>
<td></td>
<td></td>
<td>towards an agreed purpose</td>
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<tr>
<td></td>
<td></td>
<td>Highly connected network</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Low expectation of reciprocation</td>
</tr>
<tr>
<td>Antecedents</td>
<td>Individual, local and national initiatives</td>
<td>Educational preparation, maturity and experience to ensure readiness</td>
</tr>
<tr>
<td></td>
<td>Commitment to shared vision about joint venture</td>
<td>Understanding and acceptance of role and expertise</td>
</tr>
<tr>
<td></td>
<td>Willingness to sign up to creating a relationship that will support a vision</td>
<td>Confidence in ability and recognition of disciplinary boundaries</td>
</tr>
<tr>
<td></td>
<td>Value co-operation and respect for what other partners bring to the relationship</td>
<td>Effective communication, respect for and understanding of other’s roles</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Sharing of knowledge, values, responsibility, visions and outcomes</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Trust in collaborators</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Non-hierarchical organization with individual autonomy</td>
</tr>
<tr>
<td></td>
<td></td>
<td>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</td>
</tr>
</tbody>
</table>
Conclusion

This chapter has set the wider context in which the concept of partnership is located. 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 suggest 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

Table 1.2 (continued)

<table>
<thead>
<tr>
<th>Consequences</th>
<th>Partnership</th>
<th>Collaboration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Benefits</td>
<td>Social exclusion tackled more effectively through multidisciplinary action. Less repetition of service provision from different organizations. Less dilution of activities by agencies. Less chance of agencies producing services that are counterproductive to each other.</td>
<td>Benefits</td>
</tr>
<tr>
<td>Barriers:</td>
<td>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. Interprofessional differences of perspective. Threats to professional identity.</td>
<td>Connection</td>
</tr>
</tbody>
</table>
going to be the future ways of working together, old forms of professional education and training will 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. What seems clear, however, is that certain problems will, by their nature, be more amenable to a partnership or collaborative approach. As such, more work needs to be done so that the context can keep up with the concept.

Questions for further discussion
1. What attributes of partnership and collaboration have you found in evidence within your own organization?
2. What benefits (if any) of partnership and collaboration have you observed in your organization?
3. How can the barriers to partnership and collaboration be overcome?

References


