Mind the Gaps: Managing Difference in Partnership Working

Abstract

Community Health Partnerships in Scotland have been given a renewed centrality in Health policy during 2014. They have, however, experienced mixed success in their 10 years to date. Drawing on interviews with senior managers in a large Community Health Partnership, this paper highlights the challenges of leading and managing change and integration across organizational boundaries, seeks to learn from the failures that occurred, and considers the implications for policy implementation in the future.

Keywords: partnerships, change, integration, policy implementation

Mind the Gaps: Managing Difference in Partnership Working

Introduction

Partnership working has been enshrined in public policy in the UK for many years (Diamond, 2006) and its rationale rehearsed in policy and academic publications. In many respects, partnership is an organising form that sits somewhere between markets and hierarchies (Jackson & Stainsby, 2000) although the term 'partnership' has come to be used in so many inconsistent ways, that it can often also be used to describe more market-based types of interaction (Dickinson & Glasby, 2010).

Partnerships have been introduced in many sectors including housing, education health and criminal justice (Geddes, 2012), and are defined and structured differently depending on local, historical, financial, social and political considerations. Irrespective of their differences, they are almost universally designed to deal with "wicked problems" (Rittel & Webber, 1973) by enhancing the quality of public service delivery and improving outcomes (Jackson & Stainsby, 2000; Wimbush, 2011). Partnerships have also been adopted with the specific objective of improving public health outcomes in the UK (Baggott, 2005; Hunter et al., 2011; Peckham, 2007), with "Sure Start" and Health Action Zones widely cited examples of this approach (Bauld et al., 2005; Department for Education, 2010). Partnership success, however, is difficult to measure and involves consideration of process and outcomes (Dowling, Powell, & Glendinning, 2004); success in one does not always denote success overall. It is generally agreed though that partnerships will be unlikely to succeed in terms of outcomes if they do not develop collaborative processes, whereby a range of actors seek to solve shared problems through reciprocal relationships (Agranoff & McGuire, 2003). Whilst there are many documented partnership successes, there are also cases of disappointing results (Audit Commission, 2005; Audit Scotland, 2011; Dickinson & Glasby, 2010). Common difficulties include "collaborative inertia" (Huxham & Vangen, 2005) or "collaborative frustration" (Rigg & O'Mahony, 2012), following which outcomes and improvements that were promised, simply fail to materialise.

This paper considers as part of that collaborative process, the need to coordinate organisational changes across levels of multiple organisations and in particular, the impact of collaborative frustration on those tasked with responsibility for delivering improvements through greater service integration. The approach taken here recognises and responds to considerations addressed by Horwath and Morrison (2007) who noted that studies on collaboration often:

> *"...focus on objective, rational or structural explanations when analyzing interagency activity, fewer studies focus more on the irrational, unconscious or subjective aspects of organisational life...Yet it is against this background of confusion that senior managers...are expected to achieve the complex transition towards the goal of truly integrated and seamless services." (pp58).*

The paper is based on particular partnership types – Community Health Partnerships (CHPs) – that have been established for some 10 years in Scotland. It draws on a 3-year case study of one large CHP in Glasgow, to examine the extent to which the changes required of the partner organisations were acknowledged, understood and

managed. The study took a mixed method approach. An organizational staff survey and one-to-one interviews took place twice, one year into the creation of the CHP and then again 18 months later. The first all staff survey had a 31% response rate (n=389) and the second was almost identical (n=392). There were 109 interviews in the first phase involving staff across all levels of the organization, and 101 repeat interviews in phase two. A further 14 interviews took place with members of the professional executive (General Practitioners, Dentists, Optometrists) and 3 with senior members of the NHS Board and Council. Throughout the study, the project researcher also had a participant observer role and attended weekly CHP executive meetings, monthly professional executive meetings and occasional operational management team meetings. Other members of the research team also undertook some interviews and attended some meetings. The study covered all but 4 months of the 3-year period during which the CHP was structured and operated in its original form. The study explored key themes of organizational and professional identity; trust (in line management and senior management); partnership working and the processes of collaboration; and managing change (see Box 1). The research was highly interactive involving frequent presentations to CHP staff and the refinement of project insights in light of feedback. Although not action research per se, the study did involve some co-production of key research questions and the CHP senior management team used the research as *"a mirror by which to examine ourselves"* (CHP Intv 1). This paper is based mainly on the partnership experiences of the CHP senior management team, in particular, the challenges they faced as boundary spanners (Williams, 2002) and leaders of integration and collaboration, and is based on analysis of the interviews with them and Senior Managers in the parent organisations (Health Board and Council). Interviews were analysed thematically and themes explored here relate in particular to change management, expectations and experiences of partnership working and partnership capacity.

> **Box 1: Survey and Interview Themes**
> - Trust in line management
> - Trust in senior management
> - Professional identity
> - Organizational identity
> - Expectations of partnership working
> - Experiences of partnership working
> - Partnership capacity and boundary spanning skills
> - Change management (towards partnership working)

Community Health Partnerships

The creation of CHPs followed the perceived success of Local Healthcare Cooperatives (LHCCs) in 1999 - locally based primary and community care planning and coordinating bodies. Greater powers for Health Boards to delegate functions and to pool resources in 2002 (Community Care and Health (Scotland) Act) then paved the way for further local planning and coordination as envisaged in the NHS Reform (Scotland) Act 2004 and subsequently enabled through newly proposed CHPs. The 2004 Act required all Health Boards in Scotland to create one or more CHPs. Over time, two types of CHP emerged: one was a health only CPH that worked in partnership with the Local Authority and the other, an integrated CHP that was equally accountable to the Local Authority and Health Board (Audit Scotland, 2011). Integrated CHPs such as the one featured here, involved stronger structural and financial links than the health

only model. CHPs were expected to improve service delivery, their performance being judged in relation to 9 priority areas including public health outcomes (see Box 2). Although Scotland has devolved responsibility for health, this approach to greater local integration was entirely consistent with the policy solutions elsewhere in the UK under the New Labour Governments of Blair and Brown at the time (Asthana, Richardson, & Halliday, 2002; Clegg & McNulty, 2002; Dhillon, 2005; Lymbery, 2006).

A key feature of partnership success is high-level agreement between partners concerning the value of, and intention towards, partnership working and collaboration (Hardy, Hudson, & Waddington, 2000; Huxham & Vangen, 2005; O'Leary & Vij, 2012). This was thought to be present between the NHS and Local Councils across Scotland when CHPs were established. Yet despite this agreement, some of the more integrated CHPs based in NHS Greater Glasgow and Clyde encountered particular difficulties from very early stages, so much so that in 2010, Sir John Arbuthnott was invited by Glasgow City Council to review the Glasgow CHPs and his report found that there had been:

> *"...fundamental problems with governance arrangements, such as the lack of a clear strategy or formal agreement on what services and functions will be delivered through the integrated CHPs and the absence of a joint financial framework...Initially both partners agreed to work together to resolve their difficulties but later dissolved the integrated CHPs as they were unable to reach agreement on key issues."* (Audit Scotland, 2011) (pp19).

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Box 2: Priority Areas for CHPs
- Improving specific health outcomes
- Enabling hospital discharge and rehabilitation
- Providing more local diagnosis and treatment
- Preventing avoidable hospital admissions
- Improving health and tackling inequalities
- Supporting people at home
- Taking a systematic approach to long-term health conditions
- Providing better access to primary healthcare services
- Providing preventative services

(Audit Commission and Statutory CHP Guidance, 2004)

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The outcome of this review was the dissolution of integrated CHP structures in Glasgow at the time, but recent health reforms in Scotland set out in the Public Bodies (Joint Working) Act of 2014, place integrated new Health and Social Care Partnerships at the centre of policy development. The Act sets out a requirement for joint Health and Council decision-making in relation to adult community and some adult acute services, and potentially also children's services. This gives the events during recent years in Glasgow's integrated CHPs a renewed salience as they form part of the partnership landscape that is now subject to reform. Experiences in the past also potentially provide insights for other CHPs in Scotland as they implement new integrated structures between Health and Social Care.

Mind the Gaps

Many of the challenges associated with creating effective partnerships have been the subject of considerable attention in the public administration, organisational and health care evaluation literatures. Widely acknowledged is the need to work across

organisational boundaries, and to confront and influence the barriers that such inter-agency cooperation perpetually encounters (Huxham & Vangen, 2005; Sullivan & Skelcher, 2002) with the importance of high level agreements and clarity of outcomes and objectives featuring strongly (Dowling et al., 2004; Hudson & Hardy, 2002; Powell & Dowling, 2006; Rummery, 2009; Rummery & Coleman, 2003). Leadership and the implementation of collaborative ventures have also received attention; in particular, the skills and competencies as well as dedicated roles required to manage across organisational boundaries (Fitzgerald, Ferlie, McGivern, & Buchanan, 2013; Sullivan, Williams, & Jeffares, 2012; Williams, 2002). Fewer studies, however, address how those gaps between organisations impact upon emotions, energy, and longer-term leadership credibility of those tasked with leading collaborations within partnership structures. Given current Scottish policy is predicated on the belief that improvement in service outcomes is dependent on effective inter-agency collaboration, then concerted strategic and operational management of that gap between organisational boundaries is central to the success of partnership ventures.

Partnership literature consistently emphasises the importance of shared values and vision as being important antecedents of partnership success (Eilbert & Lafronza, 2005; Hardy et al., 2000; Hardy, Hudson, & Waddington, 2003). At one level, such values and vision can be fairly readily agreed: public sector agencies are motivated to support and care for individuals within society while seeking to reduce health and social inequalities. As such, it was of little surprise that one senior manager within one of the parent organisations in Glasgow described the collaboration as *"self evidently to me the way that you need to manage health and social care services and health improvement and those services and the planning associated with them together"* (SenHealth Intv. pg4). However, this *a priori* assumption of partnerships as a 'good thing' – which resonates throughout studies of partnership working (Diamond, 2006; Sullivan & Skelcher, 2002) – can create a false basis on which to work and a false sense of proximity between partnering organisations particularly given widely recognised, long-standing difficulties between agencies – elsewhere this has been considered an "uncritical acceptance" of partnership policies (Dickinson & Glasby, 2010). Reflecting on the experience in Glasgow, one senior manager in a parent organisation described this state as a *"cloud of slightly ill defined optimism…"* (SenHealth Intv.pg4). In some respects, the acceptability of collaboration as a means of improving service provision suggested a predisposition to partnership working that leap-frogged some of the necessary and detailed discussions at a strategic level about what a partnership might really mean in terms of decisions relating to service delivery, integration and control of local resources. In particular, there was too little discussion about the compatibility of the CHP principles with partner organisations' decision-making authority. The reality of partnership and the differing degrees of integration, it transpired, needed much more extensive consideration than they were in fact afforded due to key differences between the partner organisations that this paper now goes on to examine.

Engagement with partnerships as a strategic initiative

For the NHS Board, the emphasis on CHPs as key vehicles for the delivery of core services was considerable. The NHS Board focuses exclusively on health and health improvement (whether through primary, community or acute services) and priorities, strategies and plans are directed to that end. In the Council, however, the emphasis at

a strategic level on CHPs was present, but CHPs were not preeminent considerations as they were one of a number of vehicles for delivering a range of services including education, transport, culture and sport. The effect of this emphasis was thought by a senior NHS interviewee to therefore "*marginalise*" the CHP developments in the eyes of the Council:

> "*...social work services are a relatively marginal part of what the council is there for and a very marginal part of how success and failure will be judged. And I think that is a huge public policy issue, I mean the NHS does nothing but deliver personal care. We don't have anything else to do...it is actually what it is there to do, there is nothing else. We don't clean the streets or run museums or do sports halls....we are... an organisation that is arranged around the provision of personal care to individual people...we are judged by nothing else.*" (SenHealth Intv,p13)

Echoed by senior staff in the Council, this differential focus was seen to alter the degree of engagement with the CHP strategy as a primary mechanism for improving services in Glasgow. Community Planning Partnerships and other such structures, were seen by the Council as equally important structures for enhancing service delivery and improving outcomes of their services overall. Thus, whilst the CHP appeared to supersede other forms of organising service delivery from an NHS perspective and to encompass to some extent every part of NHS delivery (given they embraced primary and secondary care services), that was not the case from a Council perspective where CHPs became an additional organising structure that sat alongside other pre-existing arrangements.

An important effect of these differing levels of significance attributed to the CHPs was the degree of power afforded to the CHPs in their strategic and operational control by the parent organisations. Whilst from an NHS perspective CHPs were given delegated control over services and spending, this was not the case from the Council perspective:

> "*There was quite a famous, infamous meeting actually, [Senior NHS Representative] came along to our Corporate Management Team one time to explain CHPs to all the directors... And...mentioned about the responsibility, the accountability for budgets was to the CHPs directors and through that to the Director of Social Work. And the Director of Finance made it clear that no, accountability was to her for budgets, she had the ultimate say and that's different in health.*" (SenCouncil Intv 1, p4)

Ultimately, the debates became focused on the degree of control that existed: "*all the discussion and activity has been caught up in power struggles between what's happening out there, what's happening at the centre of Social Work. And we need to get beyond that.*" (SenCouncil Intv 2, p13-14)   As a senior council member explained, "*There was a fundamental dislocation at the start because the development of CHPs was between health and social work within the council, and there wasn't a strong engagement with what you might say the corporate centre.*" (SenCouncil Intv 1, p4).

Disillusioned Leaders

At its simplest level, the CHP structure involved a Senior Management Team (SMT) with a Director who was accountable to both the NHS Board Chief Exec and the Director of Social Work within the Council. The SMT comprised service heads (for Learning Disabilities, Children's Services etc.), functional heads (HR, finance) and a Head of Planning and Health Improvement. SMT members were employed by one of the partner organisations although after a time, some joint contracts were developed. Members of the SMT were expected to lead on the CHP policies at a local level and to encourage closer partnership working amongst the health and social work staff associated with the CHP. Other staff continued to be employed by one of the partner agencies but associated with a particular CHP.

At this level, CHP managers felt the differences between the partner agencies very acutely. Whilst seeking to gain the trust of the staff within their CHP, managers were themselves subject to frustrations and limitations that contradicted the underlying philosophy of the CHP:

> *"But I think everybody can feel the stress at the moment quite strongly. I think personal politics, power struggles, personal struggles are… the ability that individuals have for sabotage is just huge. And I think we knew that from before and I think it's happening now. I think that all of that happening at senior levels in the organisation has a huge impact that people don't quite understand… all these games that are going on are just horrendous…"* (CHP Intv 2, p3-4)

Many within CHP management roles saw CHPs as an opportunity to do something different, to locate decisions closer to those affected, and to be more imaginative in the use of budgets. Such potential was the catalyst for several senior staff to leave long-standing roles in partner agencies to lead change within the CHP. They considered CHPs to be *"about massive devolution"* (CHP Intv 4, p16) incurring *"seismic organisational change"* (Health Intv, p4) in terms of decision-making, resource allocation, local interventions and a willingness to alter historical patterns of behavior. CHP interviewees believed these principles were incorporated from the outset and enshrined in a range of policy and organisational documents. Yet for some the reality was hugely disappointing:

> *"I'm not given the authority to make the decisions because we don't have the resources, they're still all sitting centrally,…it's about trying to do your job with your hands tied behind your back,…What we can do is try and influence that change but too much of the power's being held centrally with some people who really don't want to devolve it because they don't trust us and think we can't do it. My own view is that we are the innovators, we are the folk that can make a difference, but we can't make the difference…"* (CHP Intv 4, p18)

Another said that the CHP opportunity had created *"a hunger to get things going but you're frustrated at every corner"* (CHP Intv 2 p5), and such emotion was not rare in the interviews. One manager was close to tears feeling unable to honour the promises given to her team that CHPs were a new and different way of working and finding herself unable to provide the clarity and resource that was needed to fulfill that ambition. These particular difficulties were exacerbated because of the public nature of the disagreements between parent organisations, which, for senior CHP managers,

meant that they were *"struggling to direct and positively motivate our teams. When they can see that we're impotent as a head of service, that we have no real decision making"* (CHP Intv 2, p5). At the same time, these staff felt that they were being *"kicked up and down"* by the parent organisations if they didn't deliver.

These differences between the parent organisations in this case, could have been anticipated and better planned for in the early stages of the CHP's formation but they were not given the attention that they required, as senior members of both parent organisations acknowledged:

> *"…if you were to rewind the clock, probably you would spend a bit more time on cultural issues at the start before you jump into your scheme of establishment…"* (SenCouncil Intv 1, p3)

> *"…we never do properly think through change programmes and properly resource them in the way that the private sector would do. If you were generating a change of this scale … you would have a big project team, you'd have much more HR and finance and organisational development capacity behind it and you would treat it as a major project like a corporate merger or something of that sort…We always…underestimate the scale of change that we are making and the support that is required to do it properly."* (Health Intv, p5).

Such differences had the effect of creating gaps in the CHP strategy very early on, causing strategic holes that, over time, generated fractures in the entire CHP landscape within Glasgow, causing considerable difficulty for those within management and leadership roles. There are too many salient quotes to be able to include here but staff spoke of the partners' *"fear about letting go"* and that doing something different was *"too scary"* (CHP Intv 2, p9); that when things get tough *"people retract back into their own culture and comfort level"* (CHP Intv 3, p10); and spoke of *"power games and battles…bun fights are all there on public display at the moment"* (CHP Intv 4, p21). Whilst these public differences and retrenchments were problematic in immediate terms, they also created a visible representation of partnership potential and worse, appeared to set the tone for the future. Speaking of the Council partner, one SMT member said:

> *"I don't think [they] understand the impact of the decisions that they make on the culture, that they are setting a culture. I've said this frequently, you make that decision and that's fine. But remember the wider implication of that is that you're setting out the culture."* (CHP Intv 2 p13)

Studies of GP fundholding, mental health and social care have repeatedly demonstrated the ways in which those delivering services have worked across organisational and professional boundaries for decades (Rummery & Coleman, 2003). CHPs, however, came with the promise that better structures and improved integration would reduce service gaps and allow greater benefits to flow from staff efforts to collaborate. Yet the differences that existed between the parent organisations and that were so visible to staff, meant that CHP team leaders and senior managers, spent much of their time trying to convince CHP staff of the benefits of partnership working, and encouraging

them to buy into a CHP identity, against the prevailing indications of the growing gaps between the two partner organisations.

Conclusion & Implications

Cultural differences were consistently referred to by interviewees throughout the study as an explanation for the problems that were encountered. Culture appears, however, to be something of a convenient labeling here that perhaps masks otherwise distinct issues. It is obvious from the discussion here that decision-making parameters, structure, control, devolution and accountability were particular areas of difficulty that ultimately led to the breakdown of this particular CHP structure. Whilst they are elements of organizational culture, they are also structures and processes that can be negotiated and more readily changed. In contrast, cultural change would suggest a more comprehensive and complex set of changes not necessarily amenable to managerial intervention as culture change tends to seek to alter deep-seated core values, beliefs and identities within organisations and their sub-groups (Davies, Nutley, & Mannion, 2000). Whilst relevant considerations within the overall research, these broader cultural considerations were not really key contributors to structural the disintegration that ensued, although they did present other challenges. One implication therefore, is that in collaborations between health and social care providers, partners need to take care differentiate between matters of culture and behavioural change and the more malleable aspects of structure and governance that might be agreed from the outset and written into terms of agreement.

There were also related tensions around risk and innovation. Local CHP managers were motivated by opportunities to innovate and yet felt constrained by the lack of decentralised control and scope to do things differently despite the promise of CHPs being to enable such change and local level flexibility. Such tensions around change, accountability, innovation, and managing risk are eloquently articulated by Amann (2006) as being a function of the interplay between government structures, managerialist ideologies and traditional bureaucracies. The Audit Scotland (2011) report recognised that CHP potential across Scotland had been limited because CHPs had not been given the authority to make the changes in service delivery and gains in health improvement that was expected of them. As such, policy success was somewhat constrained from the outset. Whilst the 2014 policy reforms will hopefully tackle this issue of authority, the difficulties of balancing innovation and risk highlighted by Amann (2006) will remain and CHP managers will still be expected to deal with the associated uncertainties and tensions that ensue. Successful policy implementation will therefore be reliant on equipping parent organisations and CHP managers to understand and manage risk and innovation within the necessary accountability and governance frameworks that will be in place.

It is recognised that effective partnership working requires different notions of leadership: leadership that is distributed across the organisation, decision making that is bottom up, and leaders who are empowered to work within and across organisations where they may not have hierarchical authority over others (Goodwin, 2000; VanVactor, 2012). These shifts in the balance of power, authority and associated resource do not sit well with the more centralised traditions of many partner organisations yet without such changes and associated performance structures, it

becomes impossible for local partnerships to realise their potential. It is here that cultural change may need to be focused, and management development directed. Structural change will go so far, but distributed leadership requires new forms of communication, interaction and power-sharing as well as staff development (VanVactor, 2012). Dickinson and Glasby's (2010) study of forensic mental health partnerships in England, suggests more is required of government to guide health and social care agencies in the 'doing' of partnership because policy implementation is more complex than government would typically recognise. It would seem that leadership within a partnership setting is one area in which such guidance could usefully be provided.

Future partnership success is in part, influenced by the history between partners (Hudson & Hardy, 2002). As such, progress towards (re)creating integrated Health and Social Care Partnerships as set out in the 2014 Act, will be affected to some extent by the experiences set out here. That said, interviewees did also identify positive experiences, and despite frustrations, contributed energy, enthusiasm and commitment to their roles, attributing such resilience to many years' experience of successive re-organisations and restructuring. Similarly, in terms of outcomes, there were achievements that all interviewees could point to in terms of better understanding different areas of service delivery, improving health, and enhancing local planning activities. Since the dissolution of the integrated structure, health and social care staff have continued to work together within the structural parameters currently in place. As one CHP senior manager said in July 2014, over time, the memories have faded a little and the tensions diminished. The view put forward was that because people still believe that partnership working is the ideal way to deliver services the hearts and minds do not need to be won over once more.

This particular account of partnership working, incorporates very candid accounts of organisational experience that are often critical (and self-critical) of the approach taken by the partner agencies. However, all parties involved expressed a desire to learn from their experiences and should be commended for allowing research access of as open a nature as was involved here in order to facilitate that learning. As such, the critique of their experiences should be seen as an opportunity to inform their own and others' future practice in relation to the current CHP reforms rather than solely as a criticism of past policy implementation. As the paper discusses, the initial CHP changes here did not attract the considered attention in terms of change management that they deserved. The 2014 policy will however need to address such changes and provide guidance on how to avoid the implementation gap that Dickinson and Glasby (2010) identify and that has been evidenced here. The leadership of change as well as management of change (Gill, 2002), the role of trust in building internal relationships at all levels to support change (Vakola, 2013) and the contribution of boundary spanners (Sullivan et al., 2012; Williams, 2002) will be key in the next policy phase if problems identified in this study are to be avoided in the future and if service and health improvement are to be achieved on the scale that is needed in Scotland.

References

Agranoff, R., & McGuire, M. (2003). *Collaborative Public Management: New strategies for local governments.* Washington, DC: Georgetown University Press.

Amann, R. (2006). The Circumlocution Ofice: A Snapshot of Civil Service Reform". *The Political Quarterly, 77*(3), 334-359.

Asthana, S., Richardson, S., & Halliday, J. (2002). Partnership Working in Public Policy Provision: A Framework for Evaluation. *Social Policy & Administration, 36*(7), 780-795.

Audit Commission. (2005). Governing Partnerships. Bridging the accountability gap (pp. 80). London: Audit Commission.

Audit Scotland. (2011). *Review of Community Health Partnerships.* Edinburgh: Audit Scotland.

Baggott, R. (2005). From Sickness to Health? Public Health in England. *Public Money and Management, 25*(4), 229-236.

Bauld, L., Judge, K., Barnes, M., Benzeval, M., Mackenzie, M., & Sullivan, H. (2005). Promoting Social Change: The Experience of Health Action Zones in England. *Journal of Social Policy, 34*(3), 427-445.

Clegg, S., & McNulty, K. (2002). Partnership working in delivering social inclusion: organizational and gender dynamics. *Journal of Education Policy, 17*(5), 587-601.

Davies, H. T. O., Nutley, S. M., & Mannion, R. (2000). Organisational culture and quality of health care. *Quality in Health Care, 9*, 111-119.

Department for Education. (2010). *The impact of Sure Start Local Programmes on five year olds and their families*. London: Department for Education.

Dhillon, J. K. (2005). The rhetoric and reality of partnership working. *Journal of Further and Higher Education, 29*(3), 211-219.

Diamond, J. (2006). Au revoir to partnerships: what's next? *International Journal of Public Sector Management, 19*(3), 278-286.

Dickinson, H., & Glasby, J. (2010). Why Partnership Working Doesn't Work. *Public Management Review, 12*(6), 811-828.

Dowling, B., Powell, M., & Glendinning, C. (2004). Conceptualising successful partnerships. *Health and Social Care in the Community, 12*(4), 309-317.

Eilbert, K. W., & Lafronza, V. (2005). Working together for community health - a model and case studies. *Evaluation and Programme Planning*(28), 185-199.

Fitzgerald, L., Ferlie, E., McGivern, G., & Buchanan, D. (2013). Distributed leadership patterns and service improvement: Evidence and argument from English healthcare. *The Leadership Quarterly, 24*, 227-237.

Geddes, L. (2012). In Search of Collaborative Public Management. The prolific and other priority offender programme. *Public Management Review, 14*(7), 947-966.

Gill, R. (2002). Change management - or change leadership? *Journal of Change Management, 3*(4), 307-318.

Goodwin, N. (2000). Leadership and the UK health service. *Health Policy, 51*, 49-60.

Hardy, B., Hudson, B., & Waddington, E. (2000). What makes a good partnership? A partnership assesment tool. Leeds: Nuffield Institute for Health.

Hardy, B., Hudson, B., & Waddington, E. (2003). *Assessing Strategic Partnership. The Partnership Assessment Tool*: Nuffield Institute for Health

Horwath, J., & Morrison, T. (2007). Collaboration, integration and change in children's services: Critical issues and key ingredients. *Child Abuse & Neglect, 31*, 55-69.

Hudson, B., & Hardy, B. (2002). What is a successful partnership and how can it be measured? In C. Glendinning, M. Powell & K. Rummary (Eds.), *Partnerships, New Labour and the Governance of Welfare*. Bristol: Policy Press.

Hunter, D. J., Perkins, N., Bambra, C., Marks, L., Hopkins, T., & Blackman, T. (2011). *Partnership Working and the Implications for Governance: issues affecting public health partnerships*. London: NIHR Service Delivery and Organisation programme.

Huxham, C., & Vangen, S. (2005). *Managing to Collaborate. The theory and practice of collaborative advantage.* London: Routledge.

Jackson, P. M., & Stainsby, L. (2000). Managing Public Sector Networked Organizations. *Public Money and Management, January-March*, 11-16.

Lymbery, M. (2006). United We Stand? Partnership Working in Health and Social Care and the Role of Social Work in Services for Older People. *British Journal of Social Work*(36), 1119-1134.

O'Leary, R., & Vij, N. (2012). Collaborative Public Management: Where Have We Been and Where Are We Going? *The American Review of Public Administration, 42*(5), 507-522.

Peckham, S. (2007). Partnership Working for Public Health. In J. Orme, J. Powell, P. Taylor & M. Grey (Eds.), *Public Health for the 21st Century. New Perspectives on Policy, Participation and Practice* (pp. 63-82). Maidenhead: Open University Press.

Powell, M., & Dowling, B. (2006). New Labour's partnerships: comparing conceptual models with existing forms. *Social Policy and Society, 5*(2), 305-314.

Rigg, C., & O'Mahony, N. (2012). Frustrations in Collaborative Working. *Public Management Review, 15*(1), 83-108.

Rittel, H. W. J., & Webber, M. M. (1973). Dilemmas in a General Theory of Planning. *Policy Sciences, 4*, 144-169.

Rummery, K. (2009). Healthy partnerships, healthy citizens? An international review of partnerships in health and social care and patient/user outcomes. *Social Science and Medicine, 69*, 1797-1804.

Rummery, K., & Coleman, A. (2003). Primary health and social care services in the UK: progress towards partnership? Evaluation Studies. *Social Science and Medicine, 56*(8), 1773-1782.

Sullivan, H., & Skelcher, C. (2002). *Working Across Boundaries: Collaboration in Public Services*. Baisingstoke, Hampshire: Palgrave Macmillan.

Sullivan, H., Williams, P., & Jeffares, S. (2012). Leadership for Collaboration. *Public Management Review, 14*(1), 41-66.

Vakola, M. (2013). Multilevel Readiness to Organizational Change: A Conceptual Approach. *Journal of Change Management, 13*(1), 96-109.

VanVactor, J. (2012). Collaborative leadership model in the management of health care. *Journal of Business Research, 65*, 555-561.

Williams, P. (2002). The Competent Boundary Spanner. *Public Administration, 80*(1), 103-124.

Wimbush, E. (2011). Implementing an outcomes approach to public management and accountability in the UK - are we learning the lessons? *Public Money and Management, 31*(3), 211-218.