Main Findings

- The majority of the literature on partnerships in public health focused upon partnership structures and processes and not outcomes

- Constantly changing policy priorities and organisational restructuring could have a detrimental impact on partnerships through having to re-negotiate the partnership with new or reconfigured agencies, or partnerships suddenly finding themselves faced with a new policy framework

- Area based partnership initiatives did not achieve better improvements to population health in contrast to comparator areas. However, there was some evidence that partnership working had helped broaden organisational understanding of the wider determinants of health and/or push the issue of health inequalities up some organisations’ agendas

- Not having the key personnel with authority to act on behalf of their respective organisations in a partnership was seen as a key deficit in successful partnership working

- ‘Local champions’ were seen as crucial in partnerships to drive the policy agenda forward

- Partnerships suffered from not having the capacity to fulfil their policy priorities due to the lack of appropriate, or adequate, financial and human resources

- In some partnerships, many of the targets focused on partnership processes or activities rather than on health outcomes
Background

There is a plethora of literature testifying to the importance of partnership working (see, for example, Clarke et al (2002); Dowling et al (2004)). However, less emphasis has been placed upon the value of partnerships themselves in regard to their purpose in achieving better outcomes in improved health and support for recipients of interventions and/or services.

This short summary of findings from a systematic literature review of partnerships in public health focuses on two interrelated issues regarded as crucial in delivering better service provision:

- Process issues - how well partners work together to achieve joint aims
- Outcome issues - how services and interventions change or are modified to reflect better outcomes for service users.

The summary highlights five key themes which emerged from the review around process and outcome issues – three under process issues, and two under outcome issues.

Methodology

Studies were selected for retrieval after abstracts and titles identified in electronic searches had been appraised for relevance. All retrieved studies judged by the reviewers to meet the inclusion criteria were put forward for critical appraisal.

The search strategy resulted in 1005 references being located through database searches and focused web-site searches. After being evaluated using the agreed inclusion criteria 35 references were included in the review.

The 35 studies comprise all those that were judged to focus, at least to some extent, on partnership working and public health outcomes. Many of the studies focus on the impact of Health Action Zones (HAZs), as that proved to be a particularly well evaluated initiative with a combination of national and local evaluations, but studies of Health Improvement Partnerships, Healthy Living Centres and a range of other partnerships were also identified.

Process issues

Engagement of senior management in partnerships

Not having the key personnel with authority to act on behalf of their organisation in a partnership was seen as a key deficit in successful partnership working. The TCRU, NFER Evaluation of the Impact of the National Healthy School Standard (2004) found that securing the engagement of senior management in local partnerships to improve the health of school children proved problematic, particularly managers from Primary Care Trusts (PCTs). Other studies (Arora et al, 1999; Geller 2001; Benzeval et al, 2002) have also highlighted the need to ensure the engagement of senior management in partnerships.

With or without the engagement of senior management, ‘local champions’ were seen as crucial in partnerships to drive the policy agenda forward (Arora et al, 1999; Benzeval et al 2002; Speller 1999).

Lack of Financial and Human Resources

A feature of the non HAZ studies reviewed was partnerships not having the capacity to fulfil their policy priorities due to the lack of financial and human resources. Frequently cited were the lack of joint funding or agencies not contributing funding, due to other priorities (Aror et al 1999; Powell et al 2001), or funding for a finite period only in the shape of grants or Service Level Agreements (Hills et al 2007).

Uncertainty around funding had a number of implications such as programmes or activities being curtailed or abandoned and...
creating uncertainty around planning for future service provision (Hills et al 2007; TCRU, NFER 2004). Looking at the national evaluation of HAZs in its totality, each of the strands concluded that the success of HAZs has been mixed and that key barriers to success included the ever-shifting policy context and short-term funding (Bauld et al 2005b; Mackenzie et al 2003; Matka et al, 2002).

Contextual challenges

Agencies engaged in partnerships do not operate in a policy vacuum and it was found that constant changing policy priorities and organisational restructuring could have a detrimental effect on partnership working through having to re-negotiate partnerships with new or reconfigured agencies, or partnerships suddenly finding themselves faced with a new policy framework. This was markedly so for HAZs.

It was originally intended that HAZs would last for seven years (Benzeval, 2003; Bauld et al, 2005b). However, many of the studies report that each new Secretary of State for Health appeared to bring a new focus for national health policy and, as a consequence, the potential future of HAZs became increasingly unclear (Benzeval, 2003; Sullivan et al, 2004; Bauld et al, 2005b). By 2000, the future funding available to HAZs had become less certain and the policy focus had shifted away from the original public health goals towards health-service related issues (Sullivan et al, 2004).

In various studies of Health Improvement Programmes (Arora et al 1999; Arora et al 2000; Benzeval et al 2002; Geller 2001; Powell et al 2001; Speller 1999), a major concern was with the restructuring of health authorities and their role to lead on health inequalities being handed to Primary Care Groups (subsequently Primary Care Trusts) and the uncertainty this caused. Such restructuring also entailed the re-configuring of partnerships and new policy networks to be formed.

In conjunction with reconfiguration of services, a major concern that emerged from many of the studies of partnerships involved ‘policy overload’ from central government. During the lifespan of many of the partnerships (particularly the HAZs), a plethora of new policy initiatives were announced and the partnerships were suddenly expected to address new priorities and targets. In addition, many of the HAZs had to work with the emergence of overlapping programmes which sometimes appeared to duplicate their own aims (CRESR 2005; Hills et al 2007; Sullivan et al 2002; Bonner 2003, Halliday et al, 2005).

Outcome issues

A major purpose of the literature review was to focus on those studies which had explicitly evaluated whether partnerships were having an impact on outcomes. Health-related outcomes are examined in the context of, first, whether the partnership affected health-related outcomes, and, second, if not, whether monitoring and evaluation mechanisms had been put in place to be able to capture such effects in the future.

Partnerships and outcomes

In relation to HAZs, one strand of the national evaluation highlights that local HAZs were often unclear about whether they should be focusing on reducing health inequalities within their local area or between their local area and the national average (Benzeval, 2003). In addition, although all of the HAZs incorporated at least some public health aims, many also appear to have perceived partnership working and the involvement of local communities as outcomes in and of themselves.

In order to try to assess the possible impact of HAZs on health outcomes more clearly, two studies drew upon an analysis of data from the Compendium of Clinical and Health Indicators (commissioned by the Department
of Health and produced by the National Centre for Health Outcomes and Development). The data set ‘brings together 150 indicators from several datasets including the Public Health Common Data Set indicators, population health outcome indicators, Our Healthier Nation indicators, clinical indicators, cancer survival indicators and others’ (Bauld et al, 2005a: 160).

The HAZ national evaluation team drew on a range of indicators with the objective of identifying whether there was a demonstrable difference between HAZ and non-HAZ areas in relation to changes in health outcomes through time. Baseline data was taken from 1997/98, the year before the first wave of HAZs, and compared with the latest available data, which was for the year 2001/02. Local authority level data was chosen to facilitate comparisons between HAZ and non-HAZ areas. Local authorities located within HAZ areas were then compared with those in non-HAZ areas which appeared to have similar levels of disadvantage (Bauld et al, 2005a; Bauld et al, 2005b).

This analysis produced some evidence to suggest that HAZs outperformed other areas in relation to a number of indicators that are related to their programmes and national policy priorities (Bauld et al, 2005a). For example, positive changes in relation to all cause mortality and CHD mortality were visible in the earlier, first-wave HAZ areas, which had had an extra year to make an impact.

However, a note of caution was sounded by the evaluators. The findings were not consistent and mortality from suicide, for example, had increased in all areas, with the largest increase being in first wave HAZ areas, even though some of these areas had prioritised suicide reduction programmes. Overall, the data employed in this strand of the national evaluation, ‘do not support the view that HAZs made greater improvements to population health than non-HAZ areas between 1997 and 2001’ (Bauld et al, 2005b: 436).

In summary, the review of the HAZ literature identified very little evidence that partnership working had impacted positively on public health outcomes, although there was some evidence that partnership working had helped broaden organisational understandings of the wider determinants of health and/or push the issue of health inequalities up some organisations’ agendas.

In regard to HImP (Health Improvement Programmes) partnerships, Directors of Public Health were pessimistic that their local HImP would improve public health in their districts (Geller, 2001). As Benzeval et al (2002: 26) state in their study of health authorities’ policies in reducing health inequalities, ‘…respondents who answered this question said that their HA [Health Authority] did have health inequalities targets. However, many of the targets cited as examples actually focused on processes or activities rather than health outcomes…’. A small proportion said that they had ‘tried and failed’ to identify appropriate targets. Other studies of HImPs have also found this to be the case (Arora et al 1999; Arora et al 2000).

The New Deal for Communities (NDC) is an area based partnership initiative designed to improve some of the most disadvantaged areas in England. One of the core elements of the programme is to reduce health inequalities and improve the health of local populations. Interventions have mainly focussed on: promoting healthy lifestyles; enhancing service provision; developing the health workforce; and working with young people. However research by Stafford et al (2008: 301) focusing upon the health inequalities impact of the programme found that: ‘There were no consistent differences between NDC and comparator areas in the pattern of health-related outcomes for different demographic groups. In other words… robust evidence of an NDC effect
was not found, either overall or in terms of differential impacts, over and above the developments in the comparator areas'.

**Monitoring and Evaluation**

A lack of monitoring and evaluation was found to constrain whether a partnership could appraise the effectiveness of its activities. A study on the Evaluation of the Impact of the National Healthy School Standard (NHSS) found that: ‘Although the NHSS national team were said to have spent time developing targets and indicators for evaluation, a usable set of indicators had not yet been agreed’ (TCRU, NFER, 2004: 50).

In respect of HAZs, even though many of the local actors involved in them were keen to produce ‘hard evidence’ to ‘prove’ the health benefits of HAZ interventions to central government and their clinical colleagues, a key problem was that, ‘relevant [comparable] data simply were not available in a usable form, as data were collected on different scales, over different time periods and with different degrees of population coverage’ (Sullivan et al, 2004: 1609).

The lack of indicators of improved outcomes overall was due to a combination of factors including: lack of agreed priorities; lack of good quality baseline data; no clear policy goals or targets set (Arora et al 1999; Arora et al 2000; Benzeval et al 2002; Geller 2001; Powell et al 2001; Speller 1999; CRESR, 2005).

**Conclusion**

The majority of the literature on partnership working focuses on the process and structure of partnerships and there is very little on whether they are achieving their desired outcomes. Dowling et al (2004: 315) in their review of partnership working and outcomes in respect of health and social care concluded that: ‘A search of the literature relating to health and social care partnerships published in the UK since 1997 reveals little hard be evidence that they deliver improved outcomes for the users of those services’. This has also found to be the case in relation to partnerships in public health.

Partnerships are not cost-free – they incur high transaction costs. Whether they add value or whether their stated aims and purposes could not be achieved through other means are issues the research will be exploring. Partnerships are axiomatically perceived to ‘a good thing’ but must be seen in the context of ‘evidence based policy’ and ‘what works’ and that evidence is remarkable for its paucity.
Bibliography

Systematic Literature Review References


Other References