



Knowledge base

Despite all we Know about Collaborative Working, Why do we Still Get it Wrong?

Paul Williams

Reader in Public Management and Collaboration, Cardiff School of Management, University of Wales Institute, Cardiff, UK

Helen Sullivan

School of Government and Society, University of Birmingham, Edgbaston, Birmingham, UK

Contact details: pmwilliams@uwic.ac.uk

ABSTRACT

There is a fund of practical and theoretical advice on how to work effectively in collaboration, but in reality outcomes are often disappointing. This paper explores aspects that frequently derail well-intentioned collaborative endeavours, drawing on research on integration in health and social care in Wales to highlight four particular areas of concern: motivation and meaning, capacity and capability, learning, and conceptualising and measuring success. Arguing that better management of these factors should improve overall effectiveness, it concludes with a plea for greater understanding of the complex interplay between structural factors and the influences of individuals.

KEY WORDS

outcomes; dynamics; practices; capabilities; integration in Wales

The collaborative imperative

Although collaborative working between health and social care in the UK has a long and chequered history, it continues to be an integral component of public policy. Central government promotes this form of working by a combination of rhetoric and exhortation, coupled with an ever-changing mixture of policy instruments, statutory duties, financial incentives and initiatives. The advantages of working in this

way are both well-rehearsed and compelling, including making the most effective and efficient use of scarce resources, and designing and delivering services to meet the complex and interrelated needs of citizens, communities and service users.

Understanding collaboration

We know a great deal about the determinants of effective collaborative working. Our knowledge

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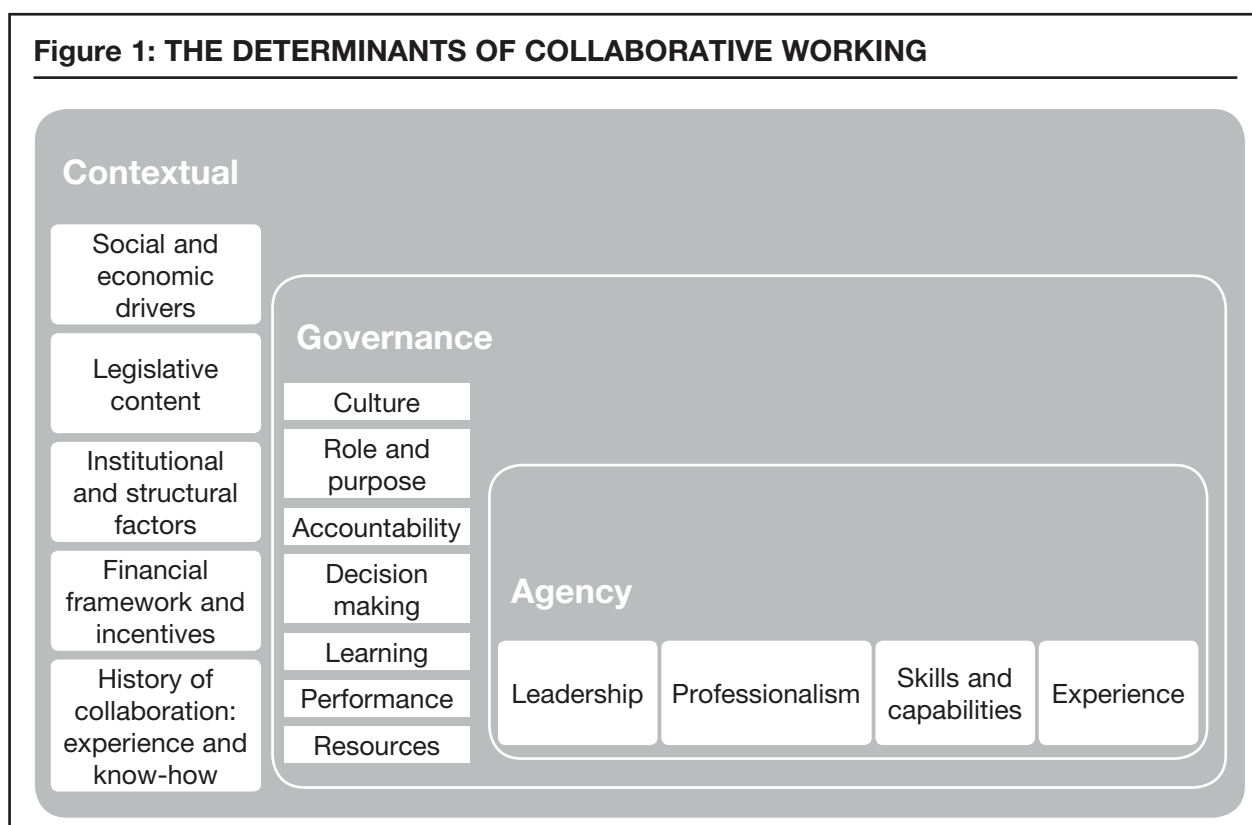
is inter-disciplinary, theoretically diverse and informed by a range of research and empirical studies (**Figure 1**, below). Theories are advanced on the drivers, structure and outcomes of collaboration (Sullivan & Skelcher, 2002; Huxham & Vangen, 2005), how to manage and govern collaboration (Peck & Dickinson, 2008; Agranoff, 2007), what form of leadership is appropriate (Crosby & Bryson, 2005; Alexander *et al*, 2001), and the role and behaviour of individuals (Kingdon, 1984; Williams, 2002). Studies of evidence-based practice consider what works (Glendinning *et al*, 2005), the drivers and barriers to effective collaboration (Cameron & Lart, 2003) and problems of interprofessionality (Hudson, 2002). Informed by this literature, a number of general and policy-specific guides provide practical advice on how to lead and manage in collaboration (CLG, 2006; Hardy *et al*, 2000; Sainsbury Centre for Mental Health, 2000; Wilson & Charleton, 1997; NLIAH, 2007; ICN, 2004; Mattessich & Monsey, 1994; Peck & Dickinson, 2008).

Regardless of these guides to action, collaborative working often proves to be ‘too difficult’ and frequently fails to live up to expectations. This paper explores why this might be the case. Despite the copious theoretical and practical evidence available, what in particular do we get wrong, and why? Are there areas of knowledge and practice that are under-researched, or is it a matter of implementation, with leaders, managers and practitioners failing to discharge their roles and responsibilities in an effective manner?

Collaboration between health and social care in Wales

The discussion draws on a research study in Wales involving integration in health and social care (NLIAH, 2009) aimed at discovering ‘what works’ from the perspectives of the managers and practitioners involved in a number of case studies. The case studies were compiled using an interrogation of relevant policy and other

Figure 1: THE DETERMINANTS OF COLLABORATIVE WORKING



documentary evidence, followed by 12–15 in-depth, qualitative interviews with different interests represented in each of the respective steering groups – professionals, practitioners, senior managers, heads of services and community representatives.

The case studies provided examples of different types of integration in different contexts. The Flintshire Children's Integrated Disability Service was precipitated by an adverse Social Services Inspectorate report which highlighted lack of co-ordination between agencies, fragmentation of resources, poor leadership and inadequate involvement with service users. The response was the establishment of a multi-agency partnership which secured co-location of service providers, wrestling along the way with issues of harmonising systems and policies, promoting generic working, and balancing the tensions between clinical and managerial accountability. However, although co-location and better co-ordination were an improvement on a previously fragmented service, closer integration was hampered by the unwillingness of certain parties to share resources and power. The Chronic Condition Management Programme in Neath, Port Talbot and Swansea (part of the national Pathways to Work Programme) was designed to support people with health problems or disabilities to secure work. Dedicated and significant resources, an integrated policy process and effective governance arrangements were able to deliver positive outcomes for service users.

The third and fourth case studies involved two examples of integrating a range of health and social care services within defined local community areas. One was the Wrexham Locality Model, which was used as the basis for delivering community health and social services in that area. A multi-agency partnership adopted an exploratory approach using pilot projects and experiments to evidence new ways of working. The other, known as the Monnow Vale Health

and Social Care Facility, involved the design and delivery of an integrated health and social care service for the people of Monmouth, including provision of a new facility with PFI funding and a Section 33 agreement to operationalise the financial and management arrangements. This example highlighted the lengthy and protracted nature of the integration process, and the difficulties of instituting integrated management arrangements in the face of differing professional and organisational interests. The final case study, the Delivering Integrated Services Project, related to the redesign of health and social care services across a wide geographical area of South-East Wales spanning a large number of diverse public, private and community organisations to achieve whole-systems change. It attempted to achieve a common vision and to engage a range of interests in different geographical and policy areas by creation of a series of pilot projects. However, major problems centred on failure to convert good intentions into effective implementation, lack of a planned strategy for individual and organisational learning, and the difficulties of maintaining the commitment of a wide and diverse set of interests.

Motivated but frustrated

The conversations with the people involved in the case studies highlighted a genuine desire to deliver high-quality public services to the most vulnerable in society. A member of the Chronic Condition Management Programme commented that:

'we know we are helping people on the ground, and to hear people who have been on the Programme speaking lifts my heart'.

They also appreciated the interdependencies between the individuals and agencies involved in the organisation and management of those services. However, the people charged with getting collaboration to work in practice felt

constantly frustrated by over-bureaucratic governance arrangements, lack of resources, inappropriate leadership, professional and institutional barriers, and the protracted nature of decision-making processes.

There was a sense that, although the rhetoric of collaboration was strong, the default position of many organisations was self-interest and turf protection, and that collaboration was often perceived as an additional responsibility and a call on limited resources and time, not an integral part of an organisation's core business. Compounding these problems was the constant threat or reality of organisational change and re-structuring, which was destabilising and compromised the often fragile collaborative structures, networks and relationships painstakingly nurtured over a long period of time. The then impending health reforms in Wales were considered by a member of the Delivering Integrated Services Project to result in 'three years' work down the drain', and another:

'in having to start all over again with both the same and different people but within a different institutional context'.

At the root of many issues lay an unquestioning belief in the virtues of collaboration, fuelled by the mantra of government policy edicts and pronouncements. In contrast to the private sector, which is far more robust in its assessment of the potential value of entering into co-operative relationships, public sector collaborations often fail to undertake any realistic cost/benefit analysis of the advantages and disadvantages of collaboration. In many cases, only the advantages are highlighted, in order to gain ownership and commitment, and the potential costs of this form of working – lost opportunity costs, process costs, loss of reputation – are ignored.

Where do things go wrong?

Collaborative working has the potential to unravel in many areas, and the evidence of this research study highlighted four particular areas of concern: motivation and meaning, capacity and capability, learning, and conceptualising and measuring success.

Motivation and meaning

Collaborative working has the potential to be derailed from the outset, and many subsequent difficulties can be traced back to its incubation. The problems relate to the multiple, and often conflicting, motivations to collaborate that the diverse set of people and organisations involved represent. They include enforced forms of collaboration as a result of statutory prescription, voluntary interactions stemming from the primacy of citizen-centred and client-focused models of care, and promotion of a more effective use of scarce public resources. Although trust, reciprocity and autonomy are emphasised in collaborative working, they invariably have different implications in voluntary and mandated forms of working. Attainment of shared purpose in an arena of multiple motivations can be highly problematic. Inextricably linked with motivation is the thorny question of meaning and interpretation. People make sense of reality in different ways, drawing on past experience, culture and professional or organisational backgrounds (Benford & Snow, 2000).

For example, in the Wrexham Locality Model, the notion of the 'locality model' was understood differently by the stakeholders involved (**Figure 2**, overleaf). There were different views about the most appropriate size of population upon which to base the locality model. Health interests favoured a larger size to justify deployment of specialist secondary care consultants, while social care stakeholders preferred a smaller size, to engage with local people and GP practices. The consequent tensions fuelled ongoing negotiation.

Figure 2: UNDERSTANDINGS OF THE LOCALITY MODEL IN WREXHAM

NHS Trust Senior Manager	• 'It means different things to different people, and can be manifested in unknown ways; to me it is about the efficient and effective use of services and a vehicle to deliver the chronic condition management agenda; but can be used to deliver other health and social care outcomes.'
NHS Trust Directorate Manager	• 'It is delivery mechanism based on geography and population size; it focuses services around a certain population that enable service providers to deliver population-sensitive services and to deliver and link different models of care that are sensitive to the needs of that population.'
Social Services Director	• 'It is a multi-disciplinary team within a geographically defined area linked to a number of GP practices.'
General Practitioner	• 'It's about fewer people in hospital beds and keeping more people at home, and a greater involvement of social services.'
NHS Trust Head of Service	• 'It's getting a balance between economies of scale, but being not too big as to not have a local feel; efficient and effective use of services but with a user focus which allows their ownership and involvement.'
LHB Chief Executive	• 'To co-ordinate the management arrangements and resources in one locality; to create an alignment between people serving the same population through effective clinical and managerial leadership resulting in a re-shaping in the use of resources.'

More fundamental are the differences in interpretation of and ambition for the process of collaboration itself, and whether it should be manifested in co-operation, co-ordination, collaboration or integration. In the absence of universally agreed definitions of these notions, meanings are imprecise and misleading (Kodner, 2009). In the case of the Flintshire Children's Integrated Disability Service views ranged widely including 'full integration and pooled budgets is the only way forward' and:

'if you have good co-ordination and respect for one another, does full integration add anything else – I'm not in favour of it'.

In South-East Wales, the project co-ordinator of the Delivering Integrated Services Project reflected that:

'the Project means different things to different people at different times'.

Statements of shared purpose, in the form of mission or core purpose statements, are typically used to focus the direction of common endeavours, but they are often pitched at too high a level of abstraction to provide any real meaning. They have the advantage of providing common ground for a diverse set of interests, but allow too much flexibility, particularly where radical changes are required. This need not be so if they are simple, realistic and collectively produced and offer compelling reasons for agencies to work collaboratively towards shared outcomes.

In practical terms, a judgement is needed on whether to seek absolute clarity of purpose at the outset from all parties, or whether to negotiate sufficient consensus to begin the process of collective action. The first strategy risks generating paralysis because of the inability to reconcile fundamental differences in values and motivations, whereas the alternative risks conflict and dissent at a later point, when matters of doing things differently and giving things up become unavoidable.

Capacity and capability

It is, perhaps, inevitable that collaborative working is not the first call on an organisation's core business but a 'bolt-on' activity with few resources. In the face of the predicted severe cuts in public service expenditure, this trend will intensify and agencies will withdraw into their primary purposes and statutory roles. The problem, however, is that collaborative management is likely to need more investment in time and resources than traditional forms of management because of the particular challenges associated with it, relating to diversity, complexity, culture, professionalism and accountability.

Dedicated resources are required to service and co-ordinate the processes, for project development and management, and to pump-prime and support pilot or new initiatives. People

are important in this equation at different levels in the organisation and with different roles. Continuity of financial resources is necessary to provide stability and avoid the uncertainties associated with short-term secondments and time-limited grants. Dedicated co-ordinator posts are as vital as senior-level actors and professionals with the capacity to engage fully and legitimately in this activity, unconstrained by the demands of 'normal' business. Over-reliance on the goodwill of mainstream staff who attempt to fit collaboration into existing heavy workloads is not a recipe for success. Part of the success of the Chronic Condition Management Programme was considered to be the full-time availability of a project manager, and one senior health manager suggested that the Flintshire Children's Integrated Disability Service 'might disintegrate' if the service manager post was removed at the termination of a time-limited grant (Joint Working Special Grant) from the Welsh Assembly Government. Lessons from the private sector suggest that companies which invest in a dedicated alliance function outperform those which do not (Dyer *et al.*, 2001). In addition, greater consideration should be given to systems of reward and incentivisation to legitimise and drive collaborative action (Ingraham & Getha-Taylor, 2008).

Critically, it is important to recognise that governing in collaboration is distinctly different from governing in single organisations, and investment is needed to develop individual and institutional capacity. Collaborative leadership is important to facilitate and design effective structures and decision-making processes to move the agenda forward in pursuit of shared purposes (**Figure 3**, overleaf). This type of leadership should be based on building and sustaining effective interpersonal relationships based on trust and reciprocity, understanding the web of interdependencies and connections that underpin collaborative exchanges, appreciating and respecting the differences in culture and

Figure 3: IMAGES OF LEADERSHIP FOR COLLABORATION

**A Health Services Chief
Executive said...**

- 'I have to put time into it, to keep people focused and on-board; I share views as well as chairing; I encourage others to participate and become involved; I value others; it's very much about visioning, being facilitative and involving others; I work across interfaces; it's important to align with others – to look for others' interests and align with their objectives.'

**A Senior Social Services
Manager said...**

- 'leadership needs to be more facilitative – to be more persuasive, influencing and helping – rather than you will.'

**A Voluntary Sector
Representative said...**

- 'he was ideal for the job, not dictatorial; facilitative but task-orientated; provided clarity of expectation; and stuck with the Project.'

perspectives that diverse partners bring to the table, promoting creativity and innovation, embracing learning and reflection, and favouring dispersed, empowering and facilitative styles of participation.

In a similar fashion, it is inappropriate to assume that professionals and managers who are competent in their mainstream job roles can be equally effective in collaborative settings. Too often people are attached to collaborative initiatives by virtue of their seniority and status, and contribute as 'organisational representatives' rather than 'partners' seeking to manufacture collaborative advantage. Boundary-spanning skills and behaviours are acquired and honed by investment in training, professional development and inter-agency learning. Boundary spanning involves networking activities to build collaborative cultures, based on effective interpersonal relationships, trust and reciprocity, brokering to bring people together to deliver win-win solutions, entrepreneurial activities to promote innovative approaches to 'wicked

problems', organisational skills to convene and co-ordinate collaborative processes, and mediation processes to align the different cultures, viewpoints and aspirations of diverse stakeholders. **Figure 4**, opposite, illustrates how boundary spanners were profiled by a number of respondents in the research study.

It is somewhat perverse that we countenance 'unskilled' people working in collaborative settings when we would never entertain such a situation in the management of individual public services. Currently, the overwhelming proportion of limited training and development budgets is directed to mainstream professional and managerial development, and not to the skills and competencies for collaborative working.

Learning

Bringing together existing knowledge and generating new knowledge are key drivers for collaboration. Knowledge transfer and learning have become important in their own right in the UK public service context, as a means of

Figure 4: STAKEHOLDER VIEWS OF BOUNDARY SPANNERS

A Manager of a Health and Social Care Service said...	• 'boundary spanners are can-do people; not professionally defensive; with a service-user focus; open and transparent, with an appreciation of the role of other agencies.'
A Social Services Director said...	• 'must be tough and personable; self-starting; able to make connections, with good negotiating skills; able to create relationships and being open to different ideas.'
A Project Co-ordinator said...	• 'concentrate on building personal relationships; investing in social networks through trust; understands, respects and listens to others; skilled in negotiation and communication.'
An NHS Trust Director said...	• 'having an awareness of the whole system; understand complexity; having a vision; not fearing change; taking risks and doing things differently.'

promoting improvement and performance, for instance in managed clinical networks (Addicott *et al*, 2006). As well as learning about service design, organisations acquire knowledge about effective management of collaborative processes which can be instrumental in promoting future collaborative behaviour. A Health chief executive referred to the collaborative process as 'social capital which has benefited other partnerships' and a nurse director talked about it as 'seeping into other pieces of work'. In addition, organisations learn about each other – their cultures, operating systems, management styles and ways of organising – gaining knowledge and practices that can be transferred between organisations. A GP in the Delivering Integrated Services Project reflected that:

'if nothing else comes out of this, there will be improved understanding through exposure to others'

and practitioners in the Monnow Vale Health and Social Care Facility that had re-organised to create a co-location of services claimed that:

'there has been more appreciation of each other's roles since we've moved in together'.

The key issue is the extent to which the 'rhetoric' of learning is translated into an explicit and planned strategy for learning and knowledge management, rather than viewed as a by-product of professionals and organisations joining together to deliberate on matters of common interest. Across the Welsh case studies the approach to learning was generally unplanned as was evidenced by the following remarks: 'any learning is *ad hoc*' (senior education manager) and 'we don't tend to capture learning formally' (service co-ordinator). However, some mechanisms were set up to acquire knowledge and stimulate learning. For example in the Delivering Integrated Services Project, a programme of 'organisational

raids', presentations, a compilation of best practice, inter-agency secondments and pilot projects were organised to precipitate change. The problem was that insufficient attention was paid to the methodologies for capturing, embedding, disseminating and formalising this learning and knowledge. There was little apparent understanding of the form of knowledge involved. Was it explicit in relation to formalised policies, systems and procedures, or was it of the tacit variety? Tacit knowledge is not easy to capture, translate or transfer, because it is internalised within individuals, acquired through experience and difficult to communicate, and does not readily move between cultures and professions.

Learning can occur at different levels – individual, group, organisation and inter-organisational – and different processes are involved. One common problem identified in the research was that learning tended to be concentrated in a relatively small cadre of individuals who happened to be associated with a particular collaborative project. The consequence of these people moving to other positions – taking their 'learning' with them – was a matter of some concern. An NHS Trust director reflected that much of the learning was:

'vested in the individual and of the tacit variety which was not codified and risked being lost to organisations'.

This was exacerbated by the lack of preparation by collaborating agencies to receive knowledge in relation to the time involved, the resources needed to support the dissemination process, the open attitudes required to embrace new ideas, the competencies involved in learning, and the absorptive capacity, skills and previous experience. Even where knowledge sharing and transfer are core objectives, knowledge exchange across organisations and professions can be limited, primarily because knowledge

management as an activity is marginal, compounded by distrust and individualistic agendas (Addicott *et al*, 2006).

The key questions arising from this discussion relate to whether learning and knowledge management should be allowed to prosper in an *ad hoc*, incremental fashion – an unplanned by-product of collaborative activity in which learning spontaneously takes root or is transferred somewhere and somehow – or whether it should be the subject of a planned approach deserving of appropriate resources and management.

Conceptualising and measuring success

What constitutes 'success' is a contested notion, grounded in the diverse understandings, motivations and ambitions of multiple partners and reinforced by separate performance management regimes and systems of accountability. An Assistant Director of Social Services stated that:

'we all have different expectations – sometimes they are expressed but sometimes they are tacit',

and a senior local authority officer commented that 'success depends upon who you ask'. Measuring 'success' is a complex process – conceptually, methodologically and practically, and Powell *et al* (2004) conclude that:

research that brings together rigorous and systematic evidence of the outcomes, causality and costs of partnerships has yet to be conducted.

Faith in the virtues of collaboration as a panacea is no substitute for robust evidence that it adds value and improves outcomes for vulnerable service users.

However, evaluation and performance – the 'cinderella' of the policy process – have

steadily risen up the agenda as a result of government exhortation about the need for 'evidence-based' policy, the impact of limited resources, and increased public scrutiny, transparency and accountability. The messages indicate that evaluation must be an integral part of the policy process, considered at the inception of collaborative processes rather than an afterthought, and deserving of a realistic investment of time, resources and capabilities to be fit for purpose. They also indicate that outcome-focused frameworks and stakeholder approaches are the most effective methodologies for exploring the impact of collaborative working, not forgetting about assessments of the value of the process – the cultivation of personal networks and the accumulation of social capital – which can provide the stepping stones for collaboration in the future. Measuring 'success' also has an important dynamic, and judgements can differ over varying time periods. The problem for practitioners is that the imperatives of politicians and political processes demand immediate results!

The evidence from the Welsh research largely confirms the difficulties associated with measuring success. Many interviewees had difficulty in articulating their own interpretations of success, staff resources and expertise were concentrated in other aspects of the policy process, and, despite awareness of the need to develop measures to reflect integrated and collaborative approaches to joint problems, the default position was invariably based on holding organisations to account individually rather than collectively. Typical comments included 'we don't really measure success' (service manager), 'we fail to demonstrate the benefits of partnership working' (social services director) and 'we don't have the skills and knowledge for evaluation and it is very complex' (senior NHS manager). In some cases the problems were made worse by lack of clarity about the subject of measurement, in other words 'how do we

measure vague models of integration?' (project co-ordinator). Overall, it was simply not possible to provide a robust indication of whether the considerable investments of time, resources and expectations were successful or not!

Conclusion

It has been suggested that there are two broad philosophical positions to co-ordination in public policy (Challis *et al*, 1988): an optimistic one that evokes an altruistic way of viewing the world coupled with persistence in the face of recurring disappointments, and a pessimistic one that believes such an approach is doomed to fail or under-achieve because of the competition, bargaining and conflict involved in the assembly of divergent groups and interests. Certainly, as is discussed above, there are a number of ways in which collaboration can 'go wrong' and:

'failed partnerships are very damaging – it reinforces original prejudices, suspicions and lack of trust' (NHS Trust director).

Collaboration is an exceedingly complex business, replete with ambiguities and paradoxes and complicated by a series of recurring tensions, including having to work independently and interdependently, to be participative and authoritarian, and to balance advocacy with common purpose. Whatever we know about the principles and determinants of effective collaborative working has ultimately to be converted into practice by managers and professionals. Clearly, this is a task for talented people as was confirmed by numerous interviewees in the research.

'The thing that makes it work in any type of structure is the personal commitment of the people' (health chief executive)

and

'it isn't organisations getting together, it's individuals sitting around a table' (nurse director).

But, while there is an onus on actors to manage effectively, there are areas of research that could usefully be explored to inform future practice, specifically the dynamics and interplay between structural factors and those concerning individuals. There is a tendency, typified in Wales, for government to assume too easily that frequent changes to the institutional and governance landscape in themselves achieve the desired changes. This approach is misguided, driven more by political expediency and belief in top-down, rational approaches to policy than by evidence-based understanding of the complex interplay between structure and agency. Future research needs to mature and move away from the generation of lists of determinants, to contributions that explore the relationships between structure and individual action (Williams & Sullivan, 2009). In addition, the way in which key individuals interpret and make sense of the world using particular ideas and policy narratives, and the effect that these have on the formulation and choice of strategic alternatives, are important areas of enquiry. The upheaval and costs of constant structural change may be entirely superfluous if other influences are not understood, addressed and factored into potential policy interventions.

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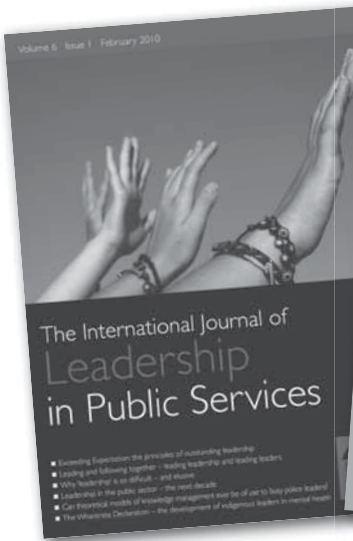
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