2

What does research tell us?

While partnership and integration are increasingly seen as a 'good thing', the evidence base underpinning such assumptions is remarkably thin. Given ongoing commitments to evidence-based policy and practice, this rather aspirational approach to partnership working and integration seems ironic to say the least – and we still know very little about the extent to which partnerships can deliver outcomes that other approaches cannot. In particular, much of the early partnership literature has tended to focus on how well agencies and professions are working together (or not), exploring the extent to which partners feel that they have a good relationship, trust each other and communicate regularly. While these are important issues, they concentrate very much on issues of *process* (how are we working together?), not on issues of *outcome* (does this make any difference to people using services?). As a result, despite a growing literature, our knowledge about what works for whom and in which circumstances remains extremely patchy (for more detailed discussion, see *Evaluating outcomes in health and social care* by Helen Dickinson, in this series).

Against this background, this chapter reviews the claims made for partnership working, and questions the extent to which they are evidence-based. In the course of this discussion, the chapter summarises the literature on what helps and hinders partnership working, and cites practical examples from various health and social care communities. In the process, the chapter also draws on evidence from private sector mergers and acquisitions, questioning the extent to which structural change alone is able to deliver different outcomes, and raising important questions about recent policy.

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Neglect of outcomes

As suggested in Chapter 1, much of the literature is extremely positive about the potential outcomes of partnership working for service users. Despite this, the fact remains that we know very little about the impact of partnership working, and many of the claims made above seem more faith- than evidence-based. As Box 2.1 suggests, most attempts to review the literature on the outcomes of partnership conclude that too few studies focus on issues of impact and effectiveness, and that our evidence base is surprisingly under-developed. For Powell and Dowling (2006, p 305), partnerships are 'the indefinable in pursuit of the unachievable'; while 'there is no shortage of advice on how to "do" partnerships … with lists of drivers, building blocks, and components…, the validity and reliability of this input into "evidence-based" policy making is less clear'.

Box 2.1: Neglect of outcomes in the partnership literature

In 2003, a systematic review of the factors promoting/hindering joint working concluded that:

> Disappointingly, the vast majority of the studies in the review focused their attention on the process of joint working and the perceptions of those involved as to its success. Very few of the studies looked at either the prior question of why joint work should be seen as a "good thing" and therefore why it should be done, or at the subsequent question of what difference joint working made. This makes the literature somewhat circular, and almost silent on the question of effectiveness. The circularity of the literature led us to the disappointing conclusion that our knowledge ... has hardly moved on since the studies carried out in the late 1970s and early 1980s. (Cameron and Lart, 2003, p 15)

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In 2012, an updated version of this review revealed similar results, adding that:

> The evidence base underpinning joint and integrated working remains less than compelling. It largely consists of small-scale evaluations of local initiatives which are often of poor quality and poorly reported. No evaluation studied for the purpose of this briefing included an analysis of cost-effectiveness. There is an urgent need to develop high-quality, large-scale research studies that can test the underpinning assumptions of joint and integrated working in a more robust manner and assess the process from the perspective of service users and carers as well as from an economic perspective. (Cameron et al, 2012, p 1)

In 2004, a review by Dowling et al (p 315) concluded that:

> The present authors' search of the literature has revealed the rudimentary state of the art of conceptualising, measuring and demonstrating the success of partnerships.... [Of studies included], only a few investigated whether specific partnerships had produced successful outcomes and the results were ambiguous even in these.… Thus … knowledge of whether partnerships "work" – in the sense of producing benefits to those who pay for, provide or use services – remains very limited.

In 2010, a review of public health partnerships identified similar results:

> This article reports on the findings from a systematic review of the impact of partnership working on public health, and considers whether these partnerships have delivered better health outcomes for local/target populations. It finds that there is little evidence that partnerships have produced better health outcomes for local/target populations or reduced health inequalities. (Perkins et al, 2010, p 101)

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Local examples

Often, the literature on integrated care seeks to overcome some of these limitations by drawing lessons from local examples and experiences. This is an important form of evidence, and can provide significant insights not available anywhere else. Such studies also shed light on the importance of local context, with different approaches seeming to work better for different areas according to local history, geography and relationships. For present purposes, this section focuses on three main studies/examples: Somerset, Torbay and the national Integrated Care Organisation pilots. The advantage of this approach is that it allows evidence from local practice and experience to inform the debate. Of course, one of the potential disadvantages is that areas with a strong reputation for joint working aren't always representative of health and social care communities elsewhere, and the lessons learned may not always be transferable.

Somerset (Peck et al, 2002)

Following a 1996 review of mental health services, Somerset Health Authority and Somerset County Council took the then unique step of establishing a joint commissioning board and an integrated health and social care provider. Equally unusually, Somerset took the brave step of commissioning a two-and-a-half-year evaluation of these innovations, choosing to make the lessons learned available nationally and publicly. In many ways, Somerset's vision then set the future trend for national policy and for other services, and the changes were subsequently taken up in mental health services and beyond across the country. However, from the beginning, the results of the Somerset study were ambiguous, and different interpretations exist as to the extent to which the integration was a success, and the insights into partnership working that this example provides (see Box 2.2).

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Box 2.2: Different interpretations of 'success'

In 2000, the government's 10-year blueprint for health services, *The NHS Plan* (DH, 2000, p 71), quoted the Somerset Partnership NHS and Social Care Trust as an example of good practice, citing benefits for service users such as the existence of a single care plan, a single key worker and a unified multidisciplinary team.

In the subsequent independent evaluation published two years later, the researchers identified evidence of an initial reduction in job satisfaction, morale and role clarity, little change in levels of user satisfaction, and ambiguous results for service users (with some improvements in coordination but also concerns about the potential closure of buildings and a loss of therapeutic/support groups) (Peck et al, 2002). Although sympathetic to what was being undertaken in Somerset and respectful of the extent to which such major change could take place with relatively little upheaval, the research presented a very different picture to that of the 2000 *NHS Plan* (DH, 2000).

While the changes in Somerset were impressive in their scope and seemed to bring about some positive changes for service users, the findings of the evaluation were nuanced. While service user satisfaction remained relatively high and consistent throughout the study, staff morale declined significantly in the short term, with concerns about workload, about a perceived loss of influence for numerically small professions and about the nature and identity of the new organisation. Although there was some evidence that service users felt that they had fewer problems keeping themselves occupied by the end of the study, it is hard to know if this was the result of the integration per se, and the problem of trying to unpick what might have happened anyway without the creation of the new Trust remains. At the same time, service user concerns about the quality of acute inpatient care, about a lack of alternatives to hospital and about a lack of respect from some staff members remained similar over time (for a summary of key findings, see Box 2.3).

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Box 2.3: Sample findings from the Somerset Partnership NHS and Social Care Trust

- In the short term, staff found that job satisfaction, morale and role clarity reduced, although this had levelled off and in some cases reversed by the end of the study.
- While the mental health status of service users improved during this period, it is not clear whether this was attributable to the integration itself.
- While coordination improved, some users were concerned about a loss of therapeutic/support groups due to changes in the use of buildings.
- There were continued concerns about lack of alternatives to hospital in a crisis, the extent to which users were involved in negotiating care plans and the attitudes of some staff.
- While there were some improvements for carers, problems continued to exist with identifying, involving and providing information to carers.

Source: Peck et al (2002)

Against this background, debate continues about exactly what these findings mean in practice. With both positives and negatives (as well as the problem of attribution), the study raised important questions about the extent to which structural change is the best way of achieving more effective partnership (see also below for further discussion):

> The establishment of the combined Trust did not – at the conclusion of the evaluation period – appear to have delivered significant benefits that have not been delivered elsewhere in England without the transfer of social care staff to NHS employment. There is no way of knowing whether comparable changes would have been achieved in Somerset without the creation of the combined Trust.… Further, this is not to say that other, and perhaps more profound, changes will not follow, especially as Somerset has already put in place the transfer of employment of most social care staff

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> that other localities may have to undertake in time. (Peck et al, 2002, p 41)

Equally, the concerns of service users about staff attitudes and about acute care do not appear to have been resolved by the creation of the Partnership Trust. Disappointing though this may be, in one sense it should hardly be surprising. If tackling these concerns was really the main priority, then arguably a different approach would have been more appropriate. Indeed, it is even possible that the integration of health and social care focused management attention so much on the *process* of partnership working that there was less emphasis on user priorities, at least in the short term.

However, perhaps the main complexity of the Somerset study is in trying to understand the overall messages that it tells us about health and social care partnerships:

- According to one reading of the Somerset story, the integration of health and social care achieved nothing that could not have been achieved with a lesser form of partnership working and less upheaval – despite all the changes, nothing essentially seemed to change for service users. If this is the case, the argument goes, it must surely raise major concerns about whether such integration is really worth the effort.
- On the other hand, other commentators look at Somerset and say that local leaders were able to pioneer new ways of working across agency boundaries and to create a new, integrated organisation – all without making anything worse for service users in the meantime. This may then have laid foundations for the future delivery of better outcomes (and we will probably now never know as a result of more recent changes in the area and in mental health services more generally, which mean that is hard to know what, if any, changes to attribute to the integration per se).

Thus, depending on your time frame and on your perspective, Somerset was either a major success or a major storm in a tea cup, and the extent

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to which partnership working really might achieve better outcomes for people who use services remains just as much a matter of faith. What is apparent, however, is that structural change can lead to potentially unintended negative outcomes in the short term, and this makes it even more important that health and social care services are clear about what they are trying to achieve and why the inevitable upheaval of organisational change is worth it in the longer run. As the lead evaluator of Somerset often says, 'success often looks like failure part way through. The problem with this is that so does failure' (personal communication). As Chapter 4 discusses, this makes the need to be clear about desired outcomes (and about the best structures and processes to achieve these ends) even more fundamental. This is even more the case since subsequent reorganisations can make it difficult to say what impacts such changes may have over time, so a local sense of what we're trying to achieve and why this is the best way forward feels crucial.

Torbay (Thistlethwaite, 2011; Farnsworth, 2012)

Following on from the pioneering work of areas such as Somerset, Peter Thistlethwaite's account of Torbay Care Trust provides a fascinating and important contribution to the literature. A key strength is that the author, a former social services senior manager and editor of the UK *Journal of Integrated Care*, was a key player locally, acting as a critical friend to the Care Trust and supporting ongoing evaluation. Thistlethwaite's description is thus more of a story than it is a formal evaluation, setting out how the Care Trust came about, what problems it was meant to solve, how local leaders tried to implement new ways of working, the key barriers and success factors, outcomes achieved and possible next steps. Although Torbay has some unique features (which may mean that the approach adopted here might not necessarily work in other areas), the paper finishes with a series of practical lessons learned which may be crucial to other areas pondering future integration (see Box 2.4). An additional account by the former chief executive also explores what the 2012 Health and Social Care Act may mean for integrated organisations such as Torbay Care Trust, and thus

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offers an important personal insight into the impact (and sometimes the unintended consequences) of recent policy changes (Farnsworth, 2012). A broader study by Miller et al (2011) looks at the mixed impact of Care Trusts more generally, and so puts the Torbay story in a broader context.

Box 2.4: Lessons from Torbay

- Base any strategy on the benefits being sought for service users/patients. Specify the benefits in advance, communicate them constantly, invest in the things that will help achieve them, monitor progress, listen to staff experiences, share results and encourage further improvement....
- Establish joint governance early (NHS, local authority and primary care).
- Invest in a professional approach to organisational development/change management over an appropriate period of time. Cultural, political and organisational differences and financial and other risks do not have to be deal breakers – they can be overcome....
- Make sure senior/middle managers and clinical leaders are engaged from the start and avoid separate management arrangements for individual professions, including social care. Be confident that individual professional practitioners will enjoy opportunities to work more closely with other professionals. Locating teams together will enhance this....
- Make sure everyone understands what is meant by the term 'integration'....

In its entirety, the Torbay approach may not travel well: Torbay is a small and compact community, with its own environment and history.... However, people in Torbay examined evidence from elsewhere, appraised their own performance, built communication and teamwork between stakeholders, made choices, managed risks and reaped rewards: these things are replicable. There is no textbook to guide the process because

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local context (especially the interplay of people, relationships and processes) is a key variable. Anyone embarking on this approach needs to conceive of it as a learning process.
Source: Thistlethwaite (2011, pp 23-4)

Integrated care pilots (RAND Europe/Ernst & Young, 2012)

Alongside specific studies in localities such as Somerset and Torbay, the DH's integrated care pilots shed light on attempts to develop more joined-up approaches in 16 different areas of the country. Focusing on different user groups and seeking to integrate in different kinds of ways, the two-year pilots were evaluated by RAND Europe/Ernst & Young (2012) and the results published (at a time when the topic of integrated care was high on the policy agenda). Unfortunately, the overall results were under-whelming, and the research team concluded that (p i):

> Integrated care led to process improvements such as an increase in the use of care plans and the development of new roles for care staff. Staff believed that these process improvements were leading to improvements in care, even if some of the improvements were not yet apparent. A range of other improvements in care were reported by pilots following local evaluations. We have reported these but they lie beyond the scope of the national evaluation.
>
> Patients did not, in general, share the sense of improvement. This could have been because the process changes reflected the priorities and values of staff (a so-called professionalisation of services); because the benefits had not yet become apparent to service users ("too early to tell"); because of poor implementation; or because the interventions were an ineffective way to improve patient experience. We believe that the lack of improvement in patient experience was in part due to professional rather than user-driven change, partly because it was too early to identify impact within the

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> timescale of the pilots, and partly because, despite having project management skills and effective leadership, some pilots found the complex changes they set for themselves were harder to deliver than anticipated....
>
> A key aim of many pilots was to reduce hospital utilisation. We found no evidence of a general reduction in emergency admissions, but there were reductions in planned admissions and in outpatient attendance.

While there were some improvements in local processes, this did not seem sufficient to significantly improve patient experience or outcomes. Although approaches such as case management might reduce some hospital costs in the long term, there was little evidence that integrated care inevitably reduces costs more generally (and certainly not in the short term). Overall, the evaluation warned policy makers that (p ii):

> The scale and complexity of delivering integrated care activities can easily overwhelm even strong leadership and competent project management. While it may seem obvious in theory that integrating activities should be scaled to match local capacity, this was not always the case in practice. In some cases, enthusiastic local leadership produced expectations that were difficult to realise in practice. Changes to practice often took much longer to achieve than anticipated.
>
> The focus on the needs and preferences of end users can easily be lost in the challenging task of building the organisational platform for integration and in organising new methods of delivering professional care. Using performance metrics focused on the end user and strengthening the user voice in the platform for integration might avoid this.
>
> When developing integrating activities there is no one approach that suits all occasions, and local circumstances and

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> path dependencies will be crucial in shaping the pace and direction of change. Integration is not a matter of following pre-given steps or a particular model of delivery, but often involves finding multiple creative ways of reorganising work in new organisational settings to reduce waste and duplication, deliver more preventive care, target resources more effectively or improve the quality of care.

At the time of writing, a series of integrated care 'pioneers' are being identified (DH, 2013), and it remains to be seen whether these will produce different outcomes or not.

What helps and what hinders?

Although the evidence on outcomes is limited, there is a growing body of literature on what partnerships themselves and other local stakeholders feel help in developing interagency relationships. Typically, this literature is much stronger on the pre-existing conditions for a successful partnership and on the factors that should exist in an ideal scenario than it is on what to do if this is not the case in your area. Put simply, there is a slightly simplistic tendency to assume that issues such as trust and reciprocity are fundamental, without necessarily exploring how best to proceed if partner agencies in your area cannot stand each other and never speak!

This overly optimistic element of the literature aside, much of the existing evidence – both from formal research and from practical experience of working in interagency settings – tends to be summarised in a series of frameworks. Often very accessible and succinct, these run the risk of trying to reduce a much more complex reality down into a series of simple 'rules', but do provide a helpful checklist against which to compare current relationships. Two prominent examples are set out in Boxes 2.5 and 2.6, and frontline practitioners and/or managers may wish to follow these up in more detail with a view to using them to understand their own local partnerships in more depth (for a further example, see also Markwell et al, 2003).

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Although such frameworks are inevitably simple in their approach, they offer a useful shorthand way of trying to understand what helps and what hinders effective partnership working. When used as the authors intended, moreover, they become more of a way of assessing current relationships, understanding what it is possible to achieve in the current context and identifying areas that require further work. At their best, therefore, such tools can help to make sense of the barriers that frontline partnerships experience, as well as offering potential insight into what needs to happen next and cautioning of the need to keep our partnership aspirations realistic.

Box 2.5: The Partnership Assessment Tool

Developed through ongoing research by the former Nuffield Institute at the University of Leeds, the Partnership Assessment Tool (PAT) provides an opportunity for a routine 'health check' of local partnerships, helps to identify areas of potential conflict and provides a developmental framework for establishing a healthy and effective partnership.

Based on six partnership principles, PAT supports local partners to rate their achievement against various key criteria, providing a quick and easy means of analysing results and identifying issues that require further work. The six key principles that PAT explores are the extent to which partners:

- recognise and accept the need for partnership
- develop clarity and realism of purpose
- ensure commitment and ownership
- develop and maintain trust
- create clear and robust partnership arrangements
- monitor, measure and learn.

Available online via the Department for Communities and Local Government, PAT is probably the best known and most widely used of such tools (Hardy et al, 2003).

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Box 2.6: The Partnership Readiness Framework

Developed by Greig and Poxton (2001), the Partnership Readiness Framework highlights the key building blocks of successful partnership:

- building and agreeing shared values and principles with a vision of how life should be for people who use services;
- agreeing specific policy shifts that the partnership arrangements are designed to achieve;
- being prepared to explore new service options and not be tied too closely to existing services or providers;
- being clear about what aspects of service and activity are inside and outside the boundaries of the partnership arrangements;
- being clear about organisational roles in terms of responsibilities for and relationships between commissioning, purchasing and providing;
- identifying agreed resource pools and putting to one side unresolved historical disagreements;
- ensuring effective leadership, including senior level commitment to the partnership agenda;
- providing sufficient partnership development capacity rather than it being a small and marginalised part of everyone's role;
- developing and sustaining good personal relationships, creating opportunities and incentives for key players to nurture these relationships in order to promote mutual trust.

Limits of structural change

If we still know relatively little about what works when it comes to health and social care partnerships, we have learned some key lessons about what does not work. In particular, there is growing evidence to suggest that structural integration – by itself – is not an effective means of achieving more effective partnerships or better outcomes for the people who use services. While this is discussed in more detail in another book in this series by Edward Peck and Helen Dickinson (*Managing and leading in inter-agency settings*), the literature on structural

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change and reorganisation (see, for example, Craig and Manthorpe, 1999; Fulop et al, 2002, 2005; Field and Peck, 2003; Edwards, 2010) suggests that:

- structural change alone rarely achieves its stated objectives;
- in addition to stated drivers for the merger, there are usually unstated drivers (such as addressing managerial or financial deficits and responding to local or national politics);
- the economic benefits are modest at best, and may be out-weighed by unanticipated direct costs and unintended negative consequences (such as a decline in productivity and morale);
- senior management time is often focused on the process of merger, and this can stall positive service development for at least 18 months (if not longer);
- the after-effects of mergers can continue for many years after the change has taken place.

Nor are outcomes necessarily better in the commercial sector. As Field and Peck (2003, p 743) have demonstrated, 'one of the key messages in the literature on [private sector] mergers is that they have happened at an astonishing pace despite the fact that they do not appear to be beneficial when judged on economic criteria'. According to one source, for instance, 54% of acquisitions were regarded as failures (Coopers & Lybrand, 1993). Consequently, many commercial organisations considering mergers have increasingly begun to pay attention to the human (cultural) factors involved in this process, rather than simply trying to create better results by changing structures.

Despite the overwhelming evidence about the limits of structural change, this remains a common approach in public services (particularly in the NHS). As Walshe (2003) has demonstrated, the NHS has been reorganised on an almost constant basis for decades, with four main impacts:

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- The proposed benefits of each reform are never achieved in practice, as the system has always been reorganised again before any meaningful evaluation can take place.
- Significant resources (both financial and human) are wasted (through the diversion of senior management time, new offices, new letterheads, new signs etc).
- The process of reform is commonly circular, with similar structures and solutions re-emerging over time.
- Constant change ironically makes the system highly change-resistant, as staff become increasingly cynical and short-term in their focus.

The overall result, as Walshe suggests in a vivid and depressingly accurate summary (2003, p 108), is that the NHS is 'an organizational shantytown in which structures and systems are cobbled together or thrown up hastily in the knowledge that they will be torn down in due course'. At various stages in recent years, of course, structural change has also been put forward as a potential solution to the problematic nature of the health and social care divide, with the Care Trust model (see Glasby and Peck, 2003; Miller et al, 2011) probably the most visible example of this approach. Thus, despite commitments to notions of 'evidence-based policy', the temptation of an apparently quick and bold structural solution seems almost too much to resist, and the risk is that we end up damaging existing health and social care partnerships in the name of trying to support and improve them. At the time of writing, this process shows no sign of abating, with strong emphasis on integrated care, but also a series of massive organisational changes that could easily damage relationships and make joint working harder in the short term.

Of course, the 2012 reforms are a good example of the way in which organisational mergers are often forced on local systems whether or not they are the best way forward in practice. In such situations, staff have no choice but to make the new organisation work as well as it possibly can, and Box 2.7 summarises some of the key messages from the literature on managing and leading during periods of merger and structural change for those agencies that are experiencing such upheavals.

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Box 2.7: Lessons from the literature on managing organisations during structural change

There are four distinct time periods within the merger process, with different approaches and management behaviour required in each different phase:

Prior to merger, it is important to assess the culture of each of the merging organisations and to use this knowledge as part of a careful strategy for highlighting and recognising the differences between the organisations.

Having decided to merge, managers and leaders should communicate a vision that sets out the purpose of changes and do this in an open and participatory manner.

During merger, key practical steps include providing practical and emotional support for staff, making human resources (HR) the main issue, communicating relentlessly, setting up clear transitional structures to guide and implement the merger, and helping staff to understand the implications of change.

After merger, it is important to monitor and evaluate the impact of the change for at least three years – both in relation to the original objectives and using other measures such as staff attitudes and service user/carer satisfaction.
Source: Dickinson et al (2006)

Whose fault is this lack of evidence?

As a postscript to this chapter, it is important to think through whose fault this situation may be. Is it the politicians (who might be accused of developing policy in advance of the evidence and jumping on the bandwagon of partnership/integrated care)? Is it academics (who have arguably been slow to respond to the partnership agenda)? Is it frontline services (who have perhaps understandably tended to focus

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more on implementing change than on evaluating its longer-term impact)? In one sense, the answer is probably that all these groups and factors have contributed to our lack of knowledge about the impact of partnership working. And yet, there is probably a fourth culprit as well – the nature of 'evidence' itself.

Although this may sound strange initially, traditional notions of 'evidence-based practice' have often been dominated by formal research and, in health and social care, by approaches associated with medicine and with science (that is, by quantitative research and by very formal and precise methods known as randomised controlled trials and systematic reviews). As a result, current debates about 'the evidence' often tend to focus only on very selective understandings of what should constitute valid evidence, and a large number of dissenting voices are often overlooked. While this is discussed in more detail elsewhere (see, for example, Rycroft-Malone et al, 2004; Glasby and Beresford, 2006; Glasby et al, 2007; Glasby, 2012b), a good example of this is the systematic reviews common in some parts of the NHS, which initially identify several thousand studies, exclude all but a very small number of quantitative studies, then conclude that there is very little research available!

Although clearly a caricature of a much more complex issue, there do seem to be clear instances in both health and social care where a narrow focus on traditional notions of what constitutes valid evidence can lead to a limited insight into the issues at stake (and the issue of health and social care partnerships may well be an example of this). As a result, it is possible that we may understand more about the nature and impact of partnerships if we adopt a different approach to understanding 'what works'. While this is a broader issue than can be dealt with in full here, possible examples include:

- Focusing not on 'what works' so much as on 'what does not work'. While we still know relatively little about the outcomes of partnership working, there is significant evidence of the limitations of single agency approaches. Instead of waiting for 'the evidence' before implementing new ways of working, therefore, an important

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step forward would be to decide what does not work in the current system, do something different and test out whether this works better (essentially a form of learning 'what works' by doing and reflecting). Inevitably, this might mean a very different role for those national bodies currently responsible for improving health and social care services and for disseminating good practice.
- Basing future decisions not just on what formal research has to tell us, but also on what we believe we have learned from previous changes and from current ways of working (essentially a move away from 'evidence-based practice' to a notion of 'practice-based evidence').
- Expanding traditional (often very medically dominated) notions of evidence to include other ways of knowing the world, such as the lived experience of users and carers, and the tacit knowledge of frontline practitioners (essentially a move away from traditional 'evidence-based practice' to a broader, more inclusive notion of 'knowledge-based practice').

Thus, the overall result of this discussion is that we do not yet know what impact partnership working has, for whom or under what circumstances. However, the reality is that we are probably unlikely to know this with any certainty for some time (if ever). As a result, the best way forward in the short term may be for health and social care practitioners and their organisations to be clear about what they are trying to achieve by working together, and to build in appropriate critical reflection and evaluation to enable them to learn as they go along. (In many ways, this builds on a broader theoretical approach known as 'realistic evaluation', and Chapter 4 provides a more detailed summary of the key concepts and frameworks that this entails.) While such an approach may not always seem very convincing to a busy manager or a national policy maker under pressure to ensure that their next policy is 'evidence-based', this nevertheless seems a more constructive way forward than arguing that we cannot do anything because we do not have enough 'evidence'.

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Reflective exercises

1. With a colleague from a different professional or organisational background, what outcomes have you been able to achieve together that you couldn't have achieved by yourself? Are these outcomes for people using services, for your organisation, for colleagues, or a combination? What helped and hindered your attempts to work together?
2. Think of a local partnership or service trying to deliver integrated care. Using the frameworks in Boxes 2.5 and 2.6, how well do local partners seem to be working together and where could they improve?
3. After reading the health and social care trade press, pick a recent example of a policy or service trying to deliver more integrated care. What would success look like for this policy/service, and how would you go about evaluating it?
4. Look at some of the formal evaluations in 'Further reading and resources' below. What types of evidence have they collected and how clear-cut/easy to interpret are their findings? If you were a minister or a local leader receiving such a study, what would you do with it in practical terms?

Further reading and resources

For key studies, see the national evaluations of partnership initiatives, such as:

- The Children's Fund (Edwards et al, 2006)
- Children's trusts (University of East Anglia, 2007)
- The Health Act flexibilities (Glendinning et al, 2002b)
- HAZs (Barnes et al, 2005)
- Intermediate care (Godfrey et al, 2005; Barton et al, 2006)
- Sure Start (Belsky et al, 2007)
- DH integrated care pilots (RAND Europe/Ernst & Young, 2012)

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At a more local level, a particularly important insight is provided by Peck et al's (2002) innovative study of health and social care partnerships in Somerset and a discussion of the Torbay experience by Thistlethwaite (2011) and Farnsworth (2012). At a national level, the RAND/Ernst & Young (2012) study of the government's integrated care pilots provides a key overview, while Glasby and Dickinson's (2009) edited text, *International perspectives on health and social care*, places the UK experience in a broader, international context. For summaries of the literature, see key reviews by Cameron and Lart (2003), Dowling et al (2004), Perkins et al (2010) and Cameron et al (2012). For a critical and more theoretical summary of the limitations of current approaches to evaluating partnerships, see Helen Dickinson's book in this series, *Evaluating outcomes in health and social care*.

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