

Partnerships: A Mechanism for Local Alcohol Policy Implementation

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1. Introduction

Over the past two decades, partnership working has become the accepted approach to addressing complex health and social problems which require ‘complex solutions’. This is not a new idea and has appeared at various times under different labels – as multi-agency collaboration, joint working, joined up thinking, inter-professional collaboration and so on. However, the ascendancy of the concept of ‘partnership’ across policy domains has accompanied a shift from more organic, loose forms of collaboration to more structured, strategically directed and regulated relationships between different organisations, professional groups and a whole range of other stakeholder groups. Partnerships have become a policy tool in the increasing devolution of policy and service delivery from central government to local levels.

In the alcohol field as elsewhere, partnership working has become widely accepted as an appropriate model for the development of policy, strategy and service delivery at local level. So much so that it was recommended in the recent Department of Health’s ‘Alcohol Improvement Programme’ as a key facilitating element for the delivery of a number of ‘high impact’ interventions to address rising rates of alcohol-related hospital admissions. Insights into the barriers to partnership working and suggestions for principles of effective collaboration are to be found in the literature which draws on other substantive areas. But, despite the apparent consensus which surrounds the use of a partnership approach, we know very little about how partnerships have evolved in the alcohol field or how effective they are as a method of developing and implementing local policy.

The research reported here set out to examine the contemporary situation regarding alcohol partnerships and to investigate the perceptions and experiences of key stakeholders regarding the influence of structural, cultural and relational factors on the dynamics of partnership working and on the potential of partnership working to address alcohol-related harm. We did not set out to measure outcomes or to evaluate the effectiveness of partnerships. Rather we wanted to reflect the experiences and the knowledge which derives from practice and involvement in the field. From the general literature on partnership approaches, we extracted a number of main issues for enquiry:

- What are the assumptions and expectations underpinning partnership approaches and what are partnerships intended to achieve?
 - What kinds of partnerships are there?
 - What are the experiences of key individuals working in partnerships and what do they see as the challenges, successes and effectiveness of their partnerships?
- Linked to this were a number of themes:
- *consensus and tension* around the dynamics of partnership working. e.g. the relationship of members to each other, their sustainability, their interaction and overlap with other partnerships or networks within the same locality; problems arising from the interface between national-regional-local structures.
 - *professional cultures*: although partnerships are intended to provide a co-ordinated response to agreed local priorities, partners are embedded in their own organisational and occupational cultures leading to possible difficulties and barriers to effective collaboration.
 - *resources*: there are likely to be considerable difficulties in prioritising and

allocating resources, linked to questions of responsibility and accountability to the partnership and to employing organisations. How do the members of partnerships deal with this and how does it influence action and decision-making?

- *power*: what role does ‘power’ play in the dynamics of local partnership working? To what extent are ‘alcohol champions’ and ‘high level’ buy-in seen as necessary elements for effective collaboration and to what extent is it achieved?

While we began the study with some key areas for exploration in mind, we also wanted to leave room for informants to relate their experiences and bring up issues which were important to them. Thus the research procedures and methods had to be flexible and allow for the emergence of new themes. Qualitative methods were chosen as most appropriate to meet those needs. A semi-structured survey was used to collect data from a greater number and wider range of informants than could be managed by face-to-face individual interview methods; but the survey was administered by telephone and the interviewer was able to encourage a considerable degree of open discussion. Interviews with key informants and two case studies were used to provide more in-depth and contextualised data. Full details of the research methods are provided in section two of this report.

It is important to locate descriptions and analyses of current partnerships within the wider policy arena and take account of the changing political and social contexts which have influenced the emergence and evolution of partnerships and collaborative working approaches. In section three of the report we provide a brief outline of the rise of partnership approaches as a model across policy domains and sketch out the changing nature of collaborative working in the alcohol field.

Findings from the study, in section four, provide an overview of partnerships working in the alcohol field at the time the data were collected, between July 2009 and April 2010. The data indicate clearly the complexity and overlapping nature of partnership structures. Furthermore, how partnerships are ‘nested’ within different organisational structures and linked into ‘networks’ was found to vary greatly across local areas and to reflect the diversity of local contexts.

In section five, perspectives of the achievements and challenges of partnership working are reported. In many ways the problems encountered in initiating, developing and sustaining alcohol partnerships are much the same as found in general studies of partnership working. While respondents were largely positive about their experiences of partnership working, they also related difficulties arising from issues such as gaining and keeping commitment – especially from the ‘top’ people, reaching a point of trust and being able to agree on shared priorities and goals, overcoming the tendency to work in ‘silos’ and cling to professional cultures, and, of course, securing resources and funding. The section highlights a considerable disparity between the ideal and the reality of partnership approaches and concludes that the partnership has to be seen *to add something of value* rather than attempt to take on all aspects of alcohol policy implementation.

Sections six and seven present two case studies. These highlight specific challenges for partnerships – working across non-coterminous boundaries in the one case and working in an area with a large rural element in the other case. The case studies also

illustrate many of the challenges outlined in section five and set them within a more specific local context.

Although we did not evaluate outcomes, we did ask respondents what they saw as their successes and achievements. Achievements and examples of how partnerships had coped with difficult situations are included in section five. In section eight, we report on how respondents spoke about the overall outcomes of partnership working. Again, a generally positive view of partnerships emerges. However, perceptions on the extent to which successes could be sustained and partnership working improved over the longer term were less hopeful. This becomes a particularly important issue at a time of rapid change in health, social welfare and criminal justice structures, cuts in resources and changing local contexts.

It should be noted that at the time we were gathering data, the winds of change were already blowing. By the time this report was written, regional and local structures had already changed and we had entered a period of transition in which local policy strategy and delivery will be required to adapt to new institutional and organisational structures and processes. This will undoubtedly affect the partnership networks which we describe in the report although we have no doubt that partnerships, as a mechanism for the delivery of local alcohol policy, will survive in some form.

2. Research Aims and Methods

2.1 Aims and research questions

The research aimed to provide an overview of partnerships in England based on the accounts and perceptions of professionals who were asked to describe their main partnership and reflect on its role, functioning and barriers to effective working. The findings reflect the study participants' own assessments of the effectiveness of the partnerships and their views on the successes and challenges to partnership working. At the same time, we wanted to provide a critical examination of the use of a 'partnership model' as a way of delivering policy at local level, and to consider what lessons can be learned from past and current experiences and how these may indicate directions for future partnership approaches.

The main questions we wanted to explore were:

- What are the wider policy contexts within which partnerships in the alcohol field have emerged and developed over recent decades and how is partnership working influenced by national and local policy contexts?
- What are the assumptions and expectations underpinning partnership approaches held by key people at national and local levels and what are partnerships intended to achieve?
- What kinds of partnerships are there and how is their effectiveness assessed by a sample of professionals involved in their operation?
- What can we learn from informants' accounts about the dynamics of partnership working: e.g. managing differences in professional cultures, organisational priorities, conflicting understanding of the issues and the solutions; issues of power and decision making?
- Are there tensions between the need for partnerships to respond to national targets while operating in very diverse local situations?
- What do partners see as the challenges and opportunities in partnership working, the factors influencing (and barriers to) partnership working within different local contexts?
- Do informants feel that their partnerships can help to achieve change in alcohol-related harms?
- What do partners feel about working within a 'culture of change'? Is change seen as an opportunity or a threat?

2.2 Methods

Data was collected in three phases between July 2009 and April 2010.

Key informant interviews

In phase one, 17 key informants were interviewed using open ended discussion schedules which asked about: informants' involvement and experience of partnership working over the course of their professional careers; their understanding of the concept of 'partnership working'; their current involvement in partnerships and experiences of current partnerships; their perceptions of the strengths and weaknesses

of partnership approaches and the evidence and rationale for partnership working; their perceptions of policy at national and/or local level and how partnership approaches fitted within alcohol policy and its implementation; issues of change, resources and priority setting and 'power' relationships were also covered. The exact content of each interview varied depending on the interviewee's professional context and background. Interviews lasted, on average, one hour and were digitally recorded with permission. Interviewees were chosen to provide insights into the development of partnership approaches over the previous two to three decades (a historical perspective), perspectives from individuals working at national, regional and local levels, and individuals coming from a range of different professional backgrounds within health and criminal justice agencies predominantly. Thematic content analysis of the interviews was used to identify main themes and issues and to inform the development of the next two phases of the study.

Telephone survey

Phase two, a semi structured telephone interview with alcohol co-ordinators/ leads at local level, was designed to explore issues of partnership working emerging from the key interviews and from the wider literature. Regional Alcohol Managers were asked for assistance in identifying named individuals in their regions. In addition, appropriate individuals involved in Crime and Disorder Reduction Partnerships (CDRP) – from 2008, Community Safety Partnerships (CSP) - were identified from lists on the Home Office web site; information on the partnership and a request for interview was sent to everyone on the list; sometimes the request was forwarded to a more appropriate colleague recommended by the initial contact. After piloting, the survey was conducted by email with telephone follow-up. In the event, almost all responses (90) were obtained by telephone interview. These interviews were not intended to be representative but to explore the research questions from the perspective of those involved in different types of partnerships, working in different geographical and socio-economic locations and with different local problems and circumstances.

The interview consisted of largely structured questions but included open questions to help capture respondents' reflections and experiences. As such, the data was used to provide simple descriptive analysis of the partnerships and to highlight and augment the thematic analysis undertaken in the first phase. The survey questions were intended to provide a description of partnership structures and processes and to explore perceptions of factors influencing effective partnership working. In designing the questionnaire, we were mindful of findings from the wider partnership literature which had indicated the importance of factors such as leadership, support within member agencies, ability to gain consensus on aims and objectives, priority setting and resource allocation and the possible advantages of partnerships with a longer – term tradition of collaborative working (Perkins *et al.* 2010).

Case studies

The final phase of the research used a 'case study' approach to explore a number of issues in more depth. It was decided to undertake two case studies in regions with the highest levels of alcohol consumption and related problems where partnership working might be seen as particularly important in delivering effective responses. In those regions, open ended, recorded interviews were conducted with a number of individuals involved in partnership working. In one area this involved 12 people: 5

(members of a police/ councillors group) interviewed as a group; a representative from public health, a youth worker manager of third sector service provider, a rural development officer, a representative from a service users' forum, a planning/ commissioner (alcohol treatment services), and a drug and alcohol community team leader. In the other case study, the 8 interviewees included: a Primary Care Trust (PCT) alcohol lead, two people from public health, a local authority officer, a county council policy officer, a strategic consultant, an alcohol programme manager and a service commissioner. Interestingly, two of the posts were joint appointments, one between a PCT and a local authority and another was located in a joint health unit (funded by the PCTs and the county council). The case study interviews were in addition to survey returns from the areas and relevant information from key interviews. In most of the data collection, we concentrated on the professional aspects of partnerships and the issues which arose in inter-professional working. Case study material was analysed using thematic, content analysis approaches.

2.3 Ethical considerations

Ethical permission was obtained from Middlesex University and from the NRES (National Research Ethics Service). Respondents were provided with information about the study and given assurances of confidentiality and anonymity. Key informants are identified in this report by 'K followed by a number; survey respondents are identified only by a number, and case study interviewees only by a general descriptive label e.g. youth worker.

3. The Policy Environment

3.1 The rise of partnership approaches as a model for policy delivery

In a review of alliances and partnerships for health promotion published in 1998, Gilles concluded that, on balance, “Alliances or partnership initiatives to promote health across sectors, across professional and lay boundaries and between public, private and non-government agencies, do work” (p99). The review came at a time of increasing emphasis on the broader social, economic and environmental influences on health and on the importance of building ‘social capital’ within communities as a way of addressing health inequalities, especially the problems faced by those living in ‘disadvantaged’ communities. Social capital was conceived as emerging from networks of co-operation, co-ordination and reciprocity which provide a framework of trust and mutual social benefit between individuals and organisations (Gilles 1998: 100). From a plethora of terms to describe collaborative working – joined up thinking, multi-agency working, cross-sectoral collaboration (etc.) - the term ‘partnership’ was adopted with increasing frequency in policy documents in diverse policy domains.

With the election of New Labour in 1997, partnerships became a key mechanism for the delivery of central policy at local levels, underpinning a large number of health and social care initiatives as part of the de-centralisation, or localisation, agenda (Peckham 2007; Smith *et al.* 2009; Perkins *et al.* 2010). The establishment of Local Strategic Partnerships (LSPs) in 2001 was intended to drive this new form of governance and consolidate efforts to promote partnerships and the development of co-ordinated strategies at local level (ODPM 2006). Seen as a way of tackling what The Audit Commission has called ‘wicked issues’ – problems which are complex and cross traditional organisational boundaries (cited in Wildridge *et al.* 2004:6) - partnerships have become accepted and ‘normalised’ as necessary and inevitable. They have been the backbone of area based re-generation initiatives (Beatty *et al.* 2010), of Health Action Zones and Health Improvement Programmes (Health Development Agency 2001) and a range of other programmes (reviewed in Smith *et al.* 2009). A glance at the briefing paper, *Health Improvement Programmes: research into practice* (Marks and Hunter 2000) and at Elston’s (2000) analysis of 50 HImPs, indicates the extent to which such initiatives had spread during the 1990s and the extent to which partnership working had become a requirement. According to Elston (2000: 9):

“Partnership working represents a crucial development in local health improvement planning and all HImPs are required to list the partners involved in producing the programme. The majority of partnerships include: NHS trusts, PCG/PCTs or general practitioners (GPs), some local authority representation, and a voluntary sector umbrella group. However, within these groupings there is considerable variety: ranging from almost total NHS dominance to the involvement of different local authority tiers and departments, voluntary sector groups, the police, the probation service, a university and the private sector (such as the local chamber of commerce). Professional NHS committees – such as local medical, dental and prescribing committees – are also common partners. In some areas, groups with particular interests are linked to the HImP – such as organisations representing black and minority ethnic groups and carers’ forums.”

As might be gathered from Elston's comment, there is no clear definition of 'partnership' although some core elements can be distinguished from the literature and from descriptions of partnerships in programme delivery. Writing somewhat later, Peckham (2007:2-3) suggests that:

“Partnerships are formal structures of relationships among individuals or groups, all of which are banded together for a common purpose. It is the commitment to a common cause – frequently purposive change – that characterises these partnerships, whether the partners are organizations or individuals, voluntary confederations of independent agencies or community assemblies developing multi-purpose and long term alliances”

However, partnerships, like their policy environments, come in different shapes and sizes; they evolve over time and from place to place; they exist at national and more local levels and there are different degrees of partnership collaboration. While Peckham draws attention to the formalised nature of partnerships, others have commented on a shift from an earlier more voluntary and flexible mode of collaboration (which seems to have been the case for the HImPs) towards a more formalised structure. As (Wildridge *et al.* 2004: 4-5) noted, *The New NHS: Modern Dependable* (1997), placed a formal duty of partnership between the National Health Service, local authorities, local voluntary and for-profit organisations. This was in contrast to an informal partnership where “organizations behave towards one another as partners regardless of the formal links” (Audit Commission 1998: 16) – a more voluntary, organic form of collaboration, characteristic, perhaps, of most partnership working prior to 1997.

Subject to changing policy contexts, shifting policy priorities and the organisational re-structuring processes which follow, partnerships survived what Perkins *et al.* (2010) see as a shift since 2002 away from a broad holistic emphasis on the social determinants of health (fundamental to 'social capital' arguments for partnership approaches and the inequalities agenda) towards healthcare issues, individual lifestyles and market style thinking. Whatever the political ideology, partnerships seem to have been adopted as a rational policy model for service delivery to tackle complex social problems. In 2010, when this study was conducted, a strong consensus could be observed across policy domains regarding the value of partnership working for local policy delivery.

Yet despite their proliferation and apparent wide spread popularity, the positive conclusion drawn by Gilles (1998) regarding their success has been questioned. Smith *et al.* (2009: 212) conclude that their review supports previous claims that: “persistent policy support for the concept is largely faith based”. This is all the more surprising in a policy environment which presses for 'evidence based' policy and practice. At the same time, as numerous authors argue, it is not easy to identify appropriate indicators for evaluating the success of partnerships. Reviewers have found few studies which use change in the target population as outcome measures. More frequently, partnerships have been assessed by indicators of the success of their initiation, operation and stability (see Smith *et al.* 2009; Perkins *et al.* 2010). The difficulty of evaluating partnerships is, perhaps, not so surprising if we take account of how partnerships have to respond to different national and local policy contexts, changing policy requirements and local priorities, and shifts in political ideology which drive

(for example) health policy and service commissioning. Within the literature which considers ‘what works’ in partnerships, there is, therefore, frequent analyses of the barriers and challenges to partnership working along with attempts to identify principles of good practice and pointers to developing effective working relationships (see e.g. Bulloch and Taylor, eds.2001; Glasby and Dickinson 2008).

Across the studies undertaken in different policy arenas, there is a high degree of consensus regarding the types of factors which are important in setting up and developing partnership approaches. As noted above, these include features of the national and local policy contexts and local socio-economic settings; they include process factors – such as ensuring the effectiveness of leadership and the engagement of senior level members - information sharing and developing clear aims and objectives, access to sufficient time and resources to initiate and sustain change, as well as overcoming professional and organisational differences in priorities, power and ‘culture’ (Wildridge *et al.* 2004; Zacocs and Edwards 2006; Perkins *et al.* 2010).

This body of literature has given rise to the development of a Partnership Assessment Tool, developed by the Nuffield Institute for Health for the Strategic Partnering Taskforce at the Office of the Deputy Prime Minister (Hardy *et al.* 2003) – in itself, witness to the increasing policy commitment to this model of implementation. The tool proposes six principles as the building blocks for successful partnership:

recognise and accept the need for partnership;

1. develop clarity and realism of purpose;
2. ensure commitment and ownership;
3. develop and maintain trust;
4. create clear and robust partnership arrangements;
5. monitor, measure and learn.

Each of the principles consists of a number of sub- principles with elements for assessment. The tool does not aim to offer solutions to addressing the problems of partnership working in local contexts; that will depend on specific local circumstances. However, discussion around the six principles and the sub-principles provides a useful summary of learning about partnership working gleaned from past experience.

In conclusion, over the past two decades, we have seen increasing emphasis on a partnership model which, in theory, is well suited to providing an appropriate prevention and harm reduction response to complex social problems, yet lacks clear evidence of effectiveness. We have considerable understanding and agreement about the factors which influence partnership working and the barriers to effective partnership approaches, yet evaluation studies (such as there are) continue to identify similar problems arising time and again in implementing and sustaining partnerships.

Partnerships in the alcohol field must be seen as evolving within this broader policy framework.

3.2 Alcohol and partnership working

Partnerships, multi-agency approaches, and attempts to develop co-ordinated strategies at local level are not new in the alcohol field. ‘Umbrella’ organisations aiming to co-ordinate local activities in the voluntary sector (treatment, counselling

and advice on problem drinking) emerged in the 1960s and their functions were later consolidated within a new organisation, Alcohol Concern, in 1983 (Thom 1999). During the 1980's, work by Tether, Robinson and colleagues provided a rationale for co-ordinated action at local level (Tether and Robinson 1986; Robinson *et al.* 1989) and suggested a model of 'partisan mutual adjustment' (Lindblom 1965) whereby agencies, although pursuing their own agendas, "*are capable of 'mutual adjustment' in that they adapt to the decisions made by other agencies, or attempt to influence them through negotiation, bargaining, and manipulation.*" (Tether and Harrison 1988, cited in Robinson *et al.* 1989: 9). They argued that: "*The development of a local strategy and its spread would be encouraged if the locality has a group which is clearly seen to be responsible for disseminating knowledge....lobbies local organisations...is a repository of ideas about good practice....*"(p10); they stressed the need for a local action group and for the organisation of multi-disciplinary and multi-professional activities.

Around the same time, a government circular HN(89)4 was issued to "*provide advice about ways local organisations can work together to plan, manage and make more effective use of existing resources to tackle the problem of alcohol misuse*" (Wallace *et al.* 1993: 319). The purpose was to encourage districts to develop alcohol strategies based on a single multi-agency approach to service delivery, an approach which Wallace *et al.* (1993: 319) saw as supported by national professional organisations and the World Health Organisation. Their national survey found that, although few areas actually had a strategy, the majority of those who did not, reported that they were in the process of developing or planning to develop one. However, the authors also found problems with implementation of strategies and recommended that a target be set for all districts and regions to have produced and implemented a multi-agency based alcohol strategy by 1995.

The creation of a network of 14 Regional Alcohol Misuse Co-ordinators in 1990, under the guidance of the Health Education Authority, was another push towards fostering collaboration between statutory health services, social care agencies and voluntary organisations and towards initiating strategy to support inter-sectoral working at local level (Means 1990; Thom *et al.* 1997). As an intermediary channel between national policy aims and front-line implementation, the Regional Alcohol Misuse Co-ordinator role reflected developments elsewhere towards setting up strategies and infra-structures to deliver more effective local initiatives (Thom and Bayley 2007). This deployment of a strategic Regional level network of co-ordinators was, as we shall see, to fade away only to be repeated nearly twenty years later. 'Alcohol Forums' were also forming in many parts of the country bringing together representatives from the police, probation, specialist health services, the voluntary sector and health sectors to consider collaborative approaches to addressing local alcohol-related problems. Over time, these Forums were to metamorphose into other networks and collaborative partnerships and adopt other titles and terminologies to reflect their changing circumstances.

These events were taking place in England at a time when the USA, Australia, New Zealand and Scandinavia in particular were trying out ways of delivering 'multi-component' programmes to tackle alcohol-related harm (Thom and Bayley 2007). In England, there were some moves towards 'multi-agency' collaboration and agreement on the need for joint approaches; but a survey of key informants and agencies carried

out in 1995/96 found “no obvious theoretical or organisational link between initiatives in the same locality” (Thom *et al.* 1997: 34). What was particular about the ‘multi-component’ approach was that it required a strategic framework with a theoretical base for initiating and developing joint action. This was well suited to the escalating shift towards a more structured formalised approach to partnership working. The main elements of the approach are listed in Box 1.

Box 1. Main features of a multi-component approach:

- the existence of a strategic framework with a theoretical basis for action,
- the identification of problems defined at local levels,
- a programme of co-ordinated action (projects) to address the problem based on an integrative programme design where singular interventions run in combination with each other and / or sequenced together over time,
- identification, mobilisation and co-ordination of appropriate agencies, stakeholders and local communities,
- clearly defined aims, objectives, indicators and measures of effectiveness for the programme as a whole,
- whole communities form the intervention group rather than individuals within the community
- emphasise modifying drinking cultures and effecting change in local policies, structures and systems
- evaluation forms an integral part of the programme from the start.

Source: Thom and Bayley (2007: 1-2)

Despite some encouragement from central government departments to become involved in addressing alcohol problems through collaborative working (e.g. Tierney and Hobbs 2003, Finney and Simmons 2003), and some experiments, in the 1990s, in mounting a ‘comprehensive’ approach towards tackling drug misuse (see Thom *et al.* 2007:3), there was little change at implementation level. Early work within the Health Education Authority linking in to the ‘multi-component’ approach came to a halt when an application to run an alcohol demonstration project in England was turned down by the Department of Health (Mathrani 1993; Thom *et al.* 1997; Thom *et al.* 1999).

3.3 Current policy support for partnership working

By 2004, when the Alcohol Harm Reduction Strategy for England was issued, there was a strong pressure towards partnership working between local stakeholders - local authorities, professional groups, the alcohol trade and ‘communities’ – and an expectation of collaboration between Drug and Alcohol Action Teams, Primary Care Trusts, Crime and Disorder Reduction Partnerships (CDRPs/CSPs) and other networks, some of which, by now, were well established. At the same time, a small scoping survey revealed that within the alcohol field, although there were many ‘multi-agency’ projects and approaches, there was still considerable fragmentation of effort and lack of co-ordinated, strategically grounded activity (Thom and Bayley 2007).

The 2004 policy document declared a ‘light touch’ from the centre allowing “flexibility for local partnerships to deliver what is needed in their area whilst staying in line with the aims of the national strategy” (p81). ‘*Safe. Sensible. Social*’ (2007) went further in setting a new, more structured implementation framework for achieving a reduction in harms. Local Area Agreement (LAA) partnerships were identified as best placed to plan a comprehensive approach bringing together the various interests (e.g. crime, health, education) involved in tackling alcohol-related harms. Among other things, Government Offices for the Region (GORs) were required to support CDRPs (later to become Community Safety Partnerships) in the development and implementation of their strategies and in April 2008, all CDRP’s were required by law to have a strategy to tackle crime, disorder and substance misuse (including alcohol-related disorder and misuse) in their area (HM Government 2007a:7). From 2008, LAAs managed the central ‘delivery contract’ between central government and local government, to negotiate and oversee the setting of targets drawn from a National Indicator Set based on area priorities (which were not all related to alcohol). Although alcohol was part of a number of national targets (e.g. on crime and anti-social behaviour), PSA 25 specifically stated the ‘reduction of the harm caused by alcohol and drugs’ as a target and the national indicator NI 39 provided the measure: ‘a reduction in the rate of alcohol-related hospital admissions’ (HM Government 2007a). While partnerships around crime, licensing and community safety had seemed to forge ahead since the turn of the century, the involvement of health and public health was often criticized as lacking or half hearted and partnerships around health were certainly less visible. NI39 provided a driver to stimulate the involvement of the health services and health professionals and it was a key factor in securing funding to initiate an Alcohol Improvement Programme (K4).

The Alcohol Improvement Programme (AIP)¹, established in April 2008 by the Department of Health to help stem the rate of alcohol-related hospital admissions, had much in common with the wider range of HIMPs mentioned earlier, in that it was linked to issues of tackling health inequalities and providing support to Primary Care Trusts in some of the more deprived communities as well as aiming to encourage action more generally across Primary Care Trusts. The programme advocated a number of ‘high impact changes’ and aimed to encourage implementation of evidence based interventions (such as identification and brief advice). Notably, from the point of view of this report, ‘partnership’ was specified as a fundamental mechanism for ensuring a strategic, coordinated response within local areas.

To achieve the level of necessary collaboration, a network of nine Regional Alcohol Managers (RAMs) was agreed and put into effect from March 2008. Their role was to facilitate the establishment of partnership working and the implementation of the AIP and to support PCT delivery of targets (interview material, several key informants). As with the previous network of Regional Alcohol Misuse Coordinators, the new RAMs formed an intermediary ‘layer’ between central government and local authorities, agencies and partnerships. As such, their function could be seen as a two way conduit for horizontal information sharing and negotiation, a cushion to dissolve tensions between central and local government and a translator of central policy to local implementation and local voices to central government. At the vertical level, the RAM function was intended to initiate and develop joint working and partnership and

foster innovative projects, approaches and initiatives to address alcohol harms. This also involved acting as a ‘broker’ between different partnership groups and agencies.

There are distinct similarities with the former Regional Alcohol Misuse Co-ordinators’ role:

“a broker to bring people together to express their views and understand each other’s point of view a bit of shuttle diplomacy between agencies..... you know being able to understand their point of view, represent it to the other party, make the other party understand and offer something to the others and so forth. So it was a bit of a negotiation role.....Part of my role was to try to get it to become a system and to get agencies to work together, to get agencies to have common standards as to how they would work with patients and their clients. So it was about quality control, it was about clinical governance, it was about (commissioning) ...and it was also about making best use of resources.” (K3).

Such sentiments regarding the role – its negotiating, communicating and liaison functions in particular – were echoed in interviews with present day Regional Alcohol Managers, who, like their former counterparts, saw themselves as facilitators rather than managers with powers to take and implement policy decisions. But, unlike the former Regional coordinators, the RAMs operated in a much more regulated and defined policy context led by, and more closely guided by, direct Department of Health involvement.

Within the Home Office, the importance of partnership as the way forward in implementing policy at local level was evidenced by the allocation of time and resources and the presence of a dedicated person to look after local partnership working. National indicators NI20 (assaults, like bruising and injury - as a proxy measure for alcohol) and NI41 (people’s perceptions of drunk or rowdy behaviour) were used to identify 50 priority areas for action in England and Wales. One and a half million was provided for a partnership support programme, paid to the CDRPs with the emphasis for spending very much on partnership working (see: http://ranzetta.typepad.com/files/top_50_list.pdf; K2).

In interviews, examples were given which demonstrated the value of partnerships in the criminal justice sphere. For example, one informant commented on alcohol arrest referral schemes which were reliant on partnership between police and drug and alcohol services and pointed out that recent research from pilot projects indicated that the better projects were those with the best partnerships (K1). Another mentioned joint working between health and enforcement:

“We are also finding in terms of like the police and the health, the emergency servicesthat reducing the burden on A&Es can be having a paramedic and a police officer out on patrol on a Saturday night and they will kind of deal with the most minor case injuries, so that these people then don’t have to go to A&Es. So again that’s another area where partnership working is actually helping to reduce the burden on a lot of people.” (K2)

3.4 Bridging the gap: communication at different policy levels

Although partnership working is endorsed across government departments and although there are cross departmental mechanisms for the development and clearance

of policy, the age old tensions between departments still exist and create difficulties for collaborative work at local levels. As one informant put it:

“Alcohol is so difficult because different departments have different takes on it and that can cause tensions as all have different agendas. Industry trying to protect industry, regulation, health etc.; the licensing act and current alcohol consultation highlight these differences. So, there is a lot of working across departments but not necessarily for the same outcomes – with alcohol, we might just have to come to a happy medium” (K8).

3.4.1 Working across government departments

A number of different government departments have interests in alcohol policy – most centrally the Department of Health, the Home Office, the Department for Culture Media and Sport, Children Schools and Families – but also the Department for Transport and the Treasury. Previous studies have documented the tensions and contradictions which arise from competing priorities, conflicting interests and pressures on departments in formulating and delivering alcohol policy (e.g. Baggott 1990). More than twenty years later, problems of working across government departments had changed little.

“...we even find, you know ... partnership working between government departments can be quite hard like with conflicting priorities... because we all have our different priorities, sometimes they can be achieved together, but the trade off isn't always comfortable. with DCMS, for instance, they want to do things to promote business, to help support them and the Home Office hasn't really got an interest in that ... it's not insurmountable but that kind of tension like even right to the top.. It can be seen in health as well DCMS want to promote businesses, but health wants us to drink a lot less and the economy is based, a lot of the economy is based on alcohol, so those are the kind of tensions you might come across.” (K1)

Structures which attempt to bridge divisions between departments do exist:

“So we've got the strategy itself 'safe sensible, sociable' but we've also got national targets as a mechanism. then there is a clear Government structure of which there is a senior officials group which is the alcohol strategy delivery group, which is senior civil servantsand outside stakeholders” (K4)

But they are not always effective and can result in delayed action. As the same informant mentioned with regard to the delivery of a particular health related facility:

“... in reality when we were developing that, we made the decision if we don't actually get something out there now, there will be nothing for PCTs, if we wait until we can try and broker an agreement across Government, it will be after the PSA period.” (K4)

For those with regional or local responsibilities, the constraints on government departments were understood but were seen to be at odds with the ideals and principles of partnership working being recommended for local policy delivery. Addressing the problem of working in 'silos' - which emerged as one of the main functions of partnerships – was found wanting in inter-departmental relationships and this had repercussions for adopting a leadership role at regional level. One interviewee, who had spent some time seconded to the civil service, commented:

“... I hadn’t realised the constraints that are on the Department of Health, around the politics of alcohol and whereas the things that are actually effective policy wise, they are not allowed to participate in .. (What sort of things?)

Well price, advertising, those sorts of big issues I know that the Department of Health are not allowed to address.... my experience of the Civil Service was the antithesis of partnership working. So for alcohol I was told I’m not allowed to talk about price because that’s the Department of Trade and Industry’s territory; you can’t talk about advertising because that’s Culture, Media and Sport; you can’t talk about alcohol and young people because that’s Children, Schools and Families; you can’t talk about alcohol and crime because that’s the Home Office etc..” ...“So....at a regional level to be leading that partnership, I wonder if actually it’s in the right place because they might say the right things in that meeting but in practice they are not going to... I was thinking they would stand a chance of influencing policy but it (the DH) sees itself purely as carrying out policy.” (K8)

3.4.2 Working across national – regional – local structures

Equally, structures were in place to bridge the national – local interface, through Regional Government Offices, where, for example, public health consultants and home office officials had a role to play as ‘brokers’ between national policy and local delivery mechanisms. Alcohol leads, and later within the health field, Regional Alcohol Managers (RAMs), were also part of an emerging infrastructure to facilitate the delivery of policy at local levels. Partnerships were meant to be an essential element of the supportive infrastructure and were to be developed to suit local contexts:

“... centre’s about guidance and setting the context and giving the people the tools to work with and then locally they have to plan what are their priorities.....local partnerships can be developed in their own ways, whatever is right for that local area, ... their actual functioning and the way they are structured, is different”. (K4)

People working within Regional Offices or at regional level were seen, therefore, as:

“.....really, really important..... (When things worked well) they’ll pick up on the government policy and be able to convey it out a lot better ... and they’ll have a good working knowledge of their areas as well, so they’ll already have those relationships in place and when you come in it’s kind of like they’ll feed into it. They can also facilitate visits out to the areas as well, like a foot in the door sort of thing, so that can be valuable for us.” (K1)

For regional and local workers, links with government departments were frequently seen as difficult, most often because those working in government departments were regarded as poor communicators and out of touch with local needs. A typical comment from an interviewee, in this case discussing the Department of Health, was:

“.... they don’t communicate with the Alcohol Coordinators unless they are PCT people, they don’t seem to know we exist, they don’t seem to understand that that is how things happen on the ground. But I suppose it must be difficult for Government departments to know what goes on at the coal face.” (K7)

Responsibility and accountability were also raised as problematic within a system which encourages partnerships. For some, for example, devolving implementation of the Alcohol Harm Reduction Strategy to local level was seen as “a cop out” because
“... it puts all the onus of non- delivery actually at grass roots level; so if the Government doesn't achieve, it's not them that don't achieve, it's us.” (K9).

Tensions arising from the different remits of government departments (well described in studies of national policy making mentioned above) were filtered down to regional and local levels. Issues were raised regarding the divisive effects of some funding streams, the difficulty of aligning very different priorities and agendas and of developing local policies and delivery systems in partnerships which were constrained by national department ‘silos’. Those working at regional level found themselves caught on the tension wires at the intersection between national and local demands and between inter-departmental boundaries at regional level. This aspect of inter-departmental partnership working at regional level has received little research attention and was only touched on in the current study.

There were positive views expressed with recognition given to the importance of the new delivery structures which were being put in place and to the usefulness of having national targets (even though these were also criticised as not entirely appropriate or adequate for local use). The regional alcohol manager's role, for example was mentioned as welcome because it,

“gives us something quite concrete actually to get our teeth into and we'll obviously be measured against the progress in those areas. We have a dedicated post to carry out that function.” (K6)

Given time, some people felt partnerships would be able to resolve their difficulties and work more effectively; for some, recent policy developments had provided an opportunity to consolidate and enhance working relationships and partnerships which had already been evolving for some years.

3.5 Conclusion

This research was conducted, therefore, at a time when partnerships were increasing in importance and number, when the local infrastructure for service delivery was becoming more structured, co-ordinated and regulated and, at the same time, when the ideals of de-centralised government and ‘localism’ were setting expectations that partnerships were the appropriate vehicle for ensuring that local needs were addressed by strategically coordinated action. This meant the emergence of a diverse range of partnership types, processes and targets in different areas. Some authorities, for example, had appointed ‘alcohol co-ordinators’ before 2008 and were more advanced than others in developing local policies and strategies. As other research has shown, when disparate groups are required to provide a co-ordinated response which may not always accord with their own professional priorities or occupational cultures, the assumption that consensus can be achieved and partnerships established can be challenged. The use of a partnership approach to tackle alcohol related harm is, therefore, a contested area which warrants closer inspection.

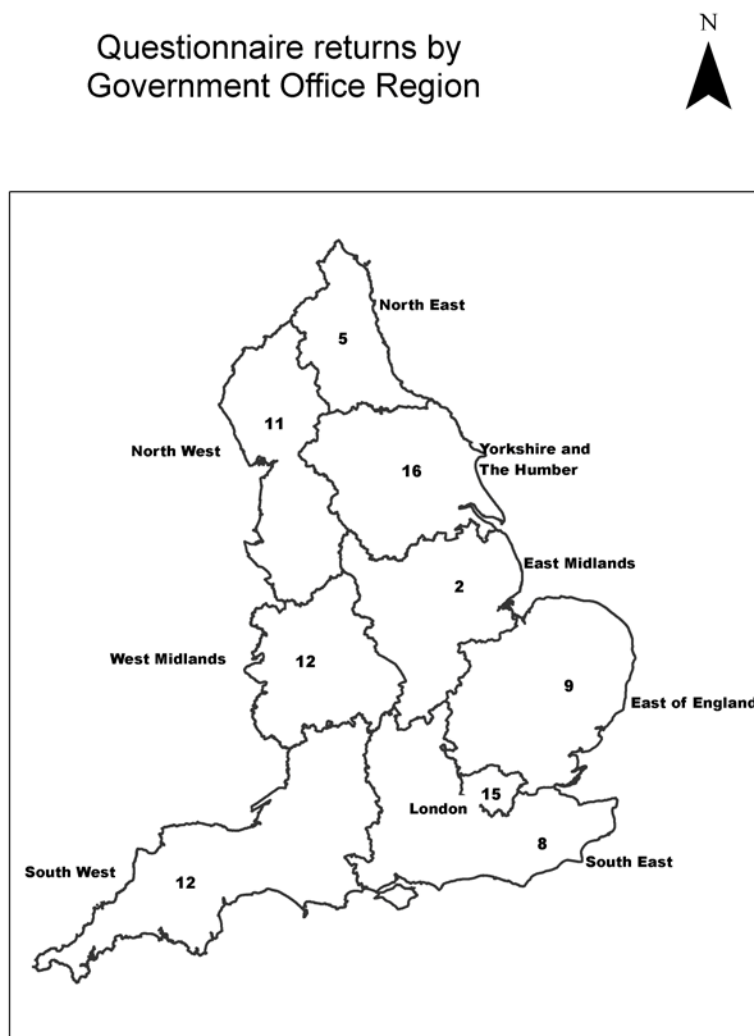
Note 1. For information on the AIP see:

<http://www.alcohollearningcentre.org.uk/SiteSearch/?quickSearch=1&page=doSearch&keywords=Alcohol+Improvement+Programme&x=45&y=14>)

4. The Partnerships: a descriptive outline

4.1 Geographic spread

As the map of the Regions shows, there were survey replies from each Region although the number varied from 16 in Yorkshire and The Humber to 2 in the East Midlands.



4.2 The respondents

Although the questionnaire was sent to alcohol co-ordinators, alcohol leads within the local DAATs and some commissioners, the job titles respondents provided showed great variation in roles and responsibilities. Levels of responsibility were well represented from top level to less senior roles. Responses included those from directors or assistant directors in public health and services, heads of community safety partnership and commissioning, as well as staff heading up projects at less

senior levels. The vast majority of respondents (90%) worked in full-time posts, although alcohol was not always the sole focus of their job.

Just under half (44%) were alcohol co-ordinators/managers or DAAT co-ordinators/managers or had roles developing or co-ordinating local alcohol strategy. Commissioning, either wholly or as a joint responsibility, was apparent in the job titles of a small number (12%); about half of these were alcohol/substance misuse co-ordinators and commissioners, while the remainder were mostly lead commissioners for either: alcohol, alcohol and drugs or substance misuse.

The field of health was well represented; roles included nursing consultants, public health consultants/managers and shared roles such as mental health and social care service managers, commissioning manager, and service managers for substance use and homelessness. Respondents also came from other fields including community safety, community planning and licensing and policy. Clearly, the job titles reflect the range of people we approached for information; but equally, they indicate the multiplicity of functions and roles represented in the partnerships.

A great deal of diversity can be seen in the professional backgrounds of respondents. Not surprisingly, many of them have backgrounds in specialist substance use services (21%), public health (14%) or nursing / medicine (11%), and social work/ social sciences (13%). Many have professional experience in enforcement - within the police, licensing, trading or community safety (19%). Training in education among adults / children and youth work was also reported (8%). Less predictably, more unusual but related backgrounds are also evident with a small number of people having worked or trained in town planning, housing or urban regeneration.

Many of the respondents had Masters level degrees, reflecting a highly educated and qualified work force with evidence of continuing professional development in their education, qualifications and skills.

These findings suggest a well qualified, experienced workforce drawn from a wide range of professional backgrounds

4.3 Respondents' employment contexts

Just under a half (46%) of respondents were employed by local authorities and county councils; over a quarter were employed by health services, either NHS or local PCTs (29%), while joint appointments (local authorities/ PCTs; DAATs/ drug and alcohol advisory services) accounted for another 14%; a further 9% were employed solely by the DAAT. The police employed 2 of the respondents (2%).

As can be seen in table1, half of the main partnerships covered an area that is completely or mostly urban (50%) or a fairly even mix of both rural and urban (44%). The predominantly urban partnerships included many city based ones, for example 15 of the 23 totally urban partnerships were based in London alone. The low level of rural partnerships may reflect a gap in the study data rather than a lack of partnerships in those areas.

Table 1. Rural/urban coverage of main partnership

Rural / urban coverage	%
Totally urban	33
Mostly urban	17
Mixed urban/rural	44
Mostly rural	4
Totally rural	1
Total	99

4.4 The trend towards partnership working

The time respondents had been in their current post varied from 2 months to 16 years, averaging out at 3.5 years.

The length of time respondents' posts had been in existence varied considerably. Nearly two thirds of the posts (63%) had been formed within the last five years, with 44% created around the period of introduction of the most recent alcohol strategy, *Safe. Sensible. Social* in 2008; 22% were less than a year old at the time of interview. Quite a significant number of posts (27%) were more than five years old with 19 years being the oldest, although some posts may have been created earlier, bearing in mind that 10% of participants did not know how long their posts had been in existence. Table 2 illustrates clearly the rise in a partnership co-ordinator function following the trend in national alcohol policy towards 'partnership approaches'.

This is confirmed by reports on the length of time main partnerships have existed. On average, partnerships had been in existence for approximately six years, although one had been developed within the last six months and a couple had been in existence for 15 years. Around half (52%) were formed less than five years ago while 40% had been in existence for more than five years. One in five (20%) were created over ten years ago which included some developed in response to the statutory requirement to have a DAAT (Drug and Alcohol Action Team) in 1995 and a CDRP (Crime and Disorder Reduction Partnership) in 1998. Around 40% of partnerships were reported as newly created, while 50% were said to have developed out of existing partnerships. However, the extent to which the older partnerships had evolved and changed over the years was commented on by respondents so that, in some cases, the current partnership bore little resemblance to its origins.

Table 2: Local alcohol co-ordinator function

Length of time respondent in post	%	When post created	%
Less than a year	20	Less than a year ago	22
1 year – less than 3 years	36	1 year – less than 3 years ago	22
3 years – 5 years	24	3 years – 5 years ago	19
More than 5 years	20	More than 5 years ago	27
Total	100	Don't know	10
Not stated	5	Total	100
		Not stated	12

4.5 The focus of the partnership

In stating the focus of the main partnership in which they were involved, 67% of respondents replied that it was a combination of health and criminal justice; health was also linked with other areas such as education, employment, social services etc for a small proportion of respondents (8%). Only three respondents (3%) stated that health alone was the focus of their main partnership. Criminal justice alone was mentioned by 14%. These findings suggest that health is now firmly on the agenda in most partnership working, possibly ‘embedded’ within broader agendas such as community safety. However, as subsequent sections will show, the marriage was not always a happy one. There were frequent comments regarding the continuing dominance of drugs where alcohol was included in Drug and Alcohol Action Teams (DAATs) or as part of community safety or Crime and Disorder Reduction Partnerships (CDRPs). There was considerable concern about poor inclusion of children and young people partnerships; and there were criticisms of the continuing ‘health’ and ‘criminal justice’ divide.

4.6 A ‘network’ of nested partnerships

The survey asked respondents to describe and comment on their *main* partnership; but we were well aware that there was a multiplicity of partnerships in the same area, many of them overlapping in their membership. Table 3 shows that the majority of partnerships overlapped with at least one other and in many cases the partnership was ‘nested’ within a bigger ‘umbrella’ group (table 4).

Table 3: Partnerships connected to main partnership

Overlap:	No
None	2
Overlaps with 1 other partnership	7
Overlaps with 2 others	21
Overlaps with 3 others	14
Overlaps with 4 others	2
Overlaps with 5 others	2
Overlaps with more than 5 others	7
All overlap with others	5
Many overlaps	3
Not applicable	1

Table 4: Umbrella groups

Umbrella group:	No
None	9
Local strategic partnership/Local Area Authority	24
CDRP; Safer Communities; Community Safety; Safer/Stronger Partnership/Communities; Stronger Communities etc	19
DAAT board	6
Health and Well-Being/Health and Social Care/Healthy area Partnership/NHS area board	8
Council executive	3
Various themed children’s boards	3
Public Service Board	2

Inevitably, the degree of overlap meant that many individuals were involved in several partnerships. The frequency of main partnership meetings varied from once a week stated by just one respondent, to three times a year, stated by another. Most partnerships (55%) met on a quarterly basis while bi-monthly or weekly meetings were held by 22% and 16% respectively. A couple of people mentioned that meeting times were under review, increasing in frequency for one and meeting less often for the other. But clearly, the overlapping nature of the partnerships increased the need for some individuals to attend meetings much more frequently and the demands on their time were considerable.

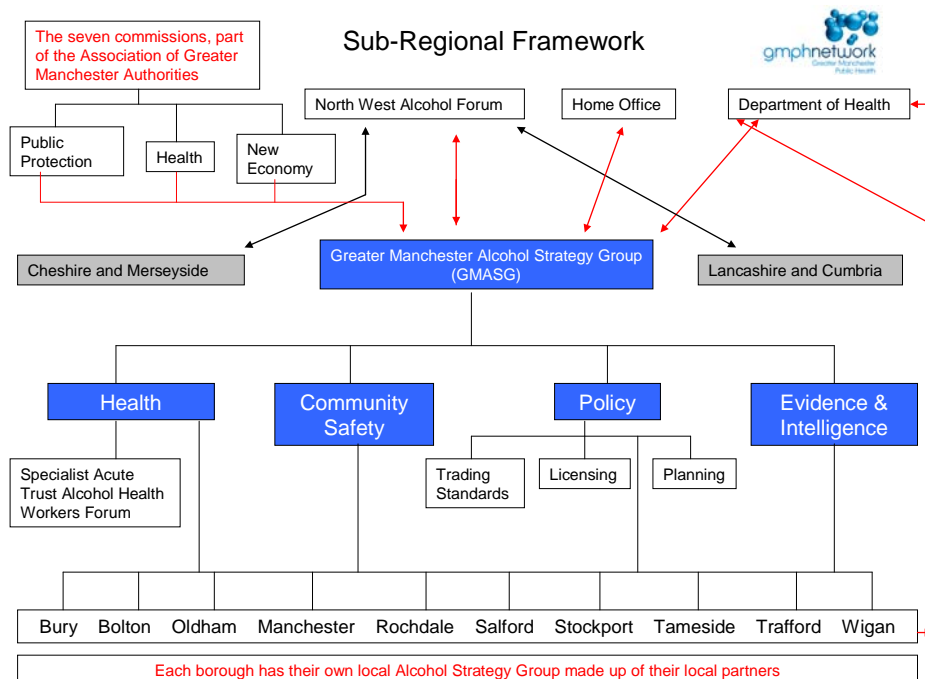
“There is a great deal of duplication in terms of personnel across the various partnerships so the same people tend to be in attendance. The main ones we would have involvement in are LSP (Local Strategic Partnership), X Children’s trust, Safer X, Safer Roads partnership, Safeguarding children board.” (53)

“Xshire is very lean in terms of staff and you will find that many senior officers will attend a myriad of partnership meetings. You may be interested to know there was a dedicated Alcohol Strategy Group set up to implement the strategy but following the first year we have agreed to collapse this group due to lack of representation. The strategy will be implemented through the Joint Commissioning Groups and Performance Management and Commissioning Group.” (09)

Overlap also meant that the lines of responsibility and accountability were sometimes complex:

“we report into the Safer X partnership Board but we are not accountable to them. We are primarily accountable to the County council. This is managed through scrutiny committees and the portfolio holder.” (16)

The diagram below provides one example of partnership ‘networks’ and ‘nests’. It is not unusual in its size and complexity. (Not connected to interviewees).



4.7 Conclusion

Based on the survey responses of the 90 individuals interviewed, this chapter has provided an overview of types of partnerships and perceptions of partnership working in the alcohol field in 2008-10 when the data was collected. Over the previous decade, there has clearly been a rise in a partnership ‘co-ordinator function’ following the trend in wider health and social policy implementation and in national alcohol policy towards ‘partnership approaches’. One major difference between partnership approaches today compared to prior forms of ‘joint working’, ‘multi-agency collaboration’ or ‘inter-sectoral collaboration’ seems to be that current partnerships have become more structured and formalised and are linked to (and embedded within) a greater number of other partnerships and organisational structures. The *requirement* to work in partnership and the role of some people to foster and build partnership working is part of the policy drive towards establishing partnership working as a primary vehicle for service delivery. This is not unique to the alcohol field. As mentioned in an earlier chapter, it crosses health and social care and was part of New Labour’s ethos to promote integrated models of working with intensified efforts from 1997 to achieve that goal. Whereas the difficulty of involving health partners in joint working had been a concern in the 1990s – when criminal justice based partnerships were emerging and consolidating – the findings suggest that health is now firmly on the agenda in most partnership working, and, in many cases, also ‘embedded’ within broader agendas such as community safety. However, this is not without its challenges.

We need to keep in mind that partnership working can cover a host of relationships: between agencies and professionals; between professionals and patients/clients; between local authorities/ professionals and ‘the community’ (itself difficult to define). The variety of job titles, employing agencies and professional backgrounds of the ninety survey respondents is indicative of the complexity of partnership networks in the alcohol field. The findings have pointed to the overlapping nature of partnerships. How partnerships are ‘nested’ within different organisational structures and linked into ‘networks’ was found to vary greatly across local areas. There are, therefore, some major issues which are often not made explicit in discussing partnership working e.g. inequalities in power between different partners and social groups. This is especially important when looking at partnerships which are intended to include lay people but it also arises in examining working relationships between different professional groups or between individuals with different institutional and organisational allegiances. In the next sections of the report, we pick up many of these issues.

5. Making Partnerships Work

5.1 Ideals and realities

Key interviewees – at all levels – subscribed to the notion of partnerships and had ideas about ideal partnership composition and functioning, for instance:

“...our ideal I guess would be frequent meetings and frequent data sharing and also sort of like marrying up of agendas” (K1).

Partnership meant more than simply ‘collaboration’ or ‘coordination’:

“...partnership probably is better than coordination. To me coordination means that people advise each other of what they are doing,you’re trying to ensure people don’t step on each other’s toes and that’s coordination in my opinion. Partnership to me is actually you invest, you invest time together, you become a partnership, you do know, you anticipate what each other is going to do, you are investing in it. So to me partnership is a little stronger than just simple coordination.” (K3)

However, the difference between the ideal and the reality was recognised by all. As the interviewee quoted above remarked:

*“I am not saying that is true.... The word partnership means to me that that is what **should** be happening, but I’m not so sure that that is what **is** happening.” (K3)*

Open ended questions in key interviews explored themes which had emerged from the literature as important for partnership working and survey respondents were asked to rate their main partnership on a number of dimensions using a scale of 5 to 1, with 5 representing the highest rating to 1 representing the lowest rating. They were also given the opportunity to comment on their answers. We were interested in finding out how respondents perceived and rated a) the structure of their main partnership, b) the processes involved in partnership working. The sections which follow are based on the findings from the 90 survey responses and are augmented by examples and information from key informant interviews.

5.2 Perceptions of partnership structures

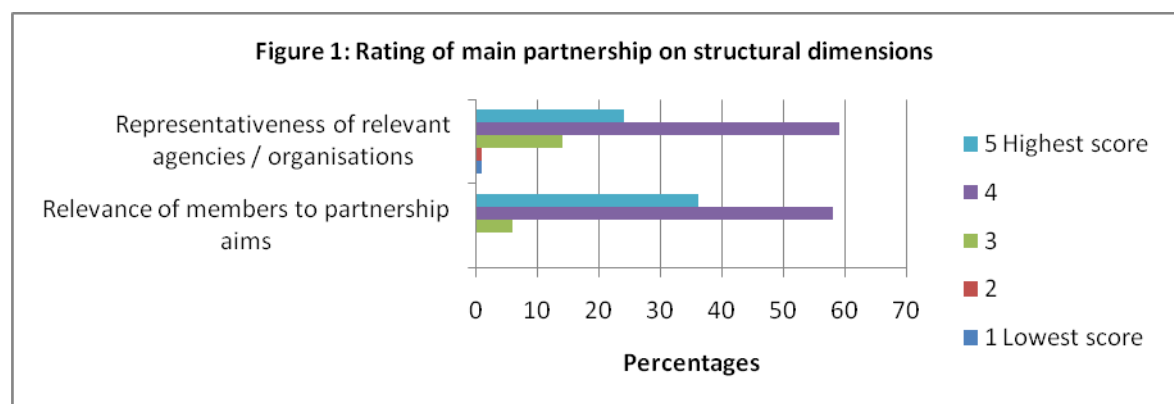


Figure 1 above shows that respondents rated the structural aspects of their main partnership very highly suggesting that, on the whole, they are satisfied with its composition. Their main partnerships have very good representation from partner

agencies and member agencies are highly relevant to the aims of the partnership. Hardly anyone rated either of these dimensions with the lowest scores (1 or 2) with most responses at the highest end of the scale. Both dimensions achieved very high mean scores of 4.05 and 4.31 respectively; these were the highest means obtained across all the dimensions respondents were asked to rate.

It would appear, therefore, that the basic foundation for partnership working – a representative, relevant membership - was seen to be in place. However, views on the process of working in partnership were much more mixed.

5.3 Perceptions of partnership processes

To probe more fully the perceived ease or difficulties experienced in working in partnerships, respondents were asked to score a set of dimensions concerned with process elements e.g. commitment from partners, decision making, sustaining the partnership, focus and priorities for action etc. The mean scores calculated for each dimension are shown in table 3 and figure 2 illustrates the responses in more detail.

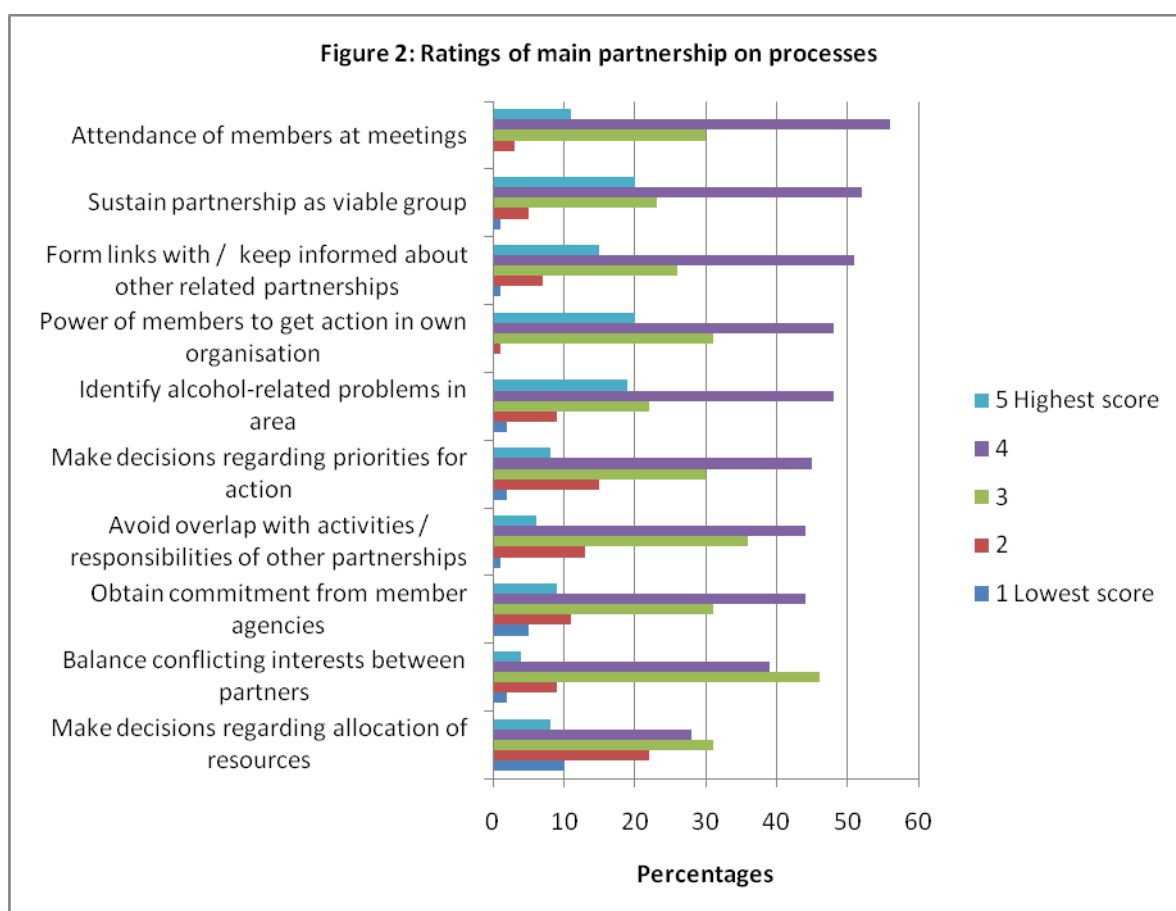
Table 3: Mean scores for rating main partnership on processes

Processes:	Means
Power of members to get action in own organisation	3.88
Sustain the partnership as viable group	3.84
Attendance of members at meetings	3.78
Identify alcohol-related problems in area	3.73
Form links with / keep informed about other related partnerships and their activities	3.71
Obtain commitment from member agencies	3.42
Make decisions regarding priorities for action	3.42
Avoid overlap with activities / responsibilities of other partnerships	3.41
Balance conflicting interests between partners	3.32
Make decisions regarding allocation of resources	3.01

Based on total number scoring each dimension

5=Highest score; 1=Lowest score

Mean scores were relatively high – although lower than for the dimensions covering partnership structure. Overall, the lower mean scores suggest that respondents were less satisfied with the process elements of their partnerships. Scores shown in figure 2 below indicate that between 5% and 20% of respondents gave a low score (2) on all dimensions and, unlike the ratings on structure, a few people rated each dimension as ‘difficult’ (score1). The issues underlying these ratings will be explored in more detail in subsequent sections and in the case studies in chapters five and six.



5.4 Main strengths and weaknesses of the partnership

- **Strengths**

Table 5 below shows that almost all respondents, except those in newly established partnerships, listed a number of strengths resulting from partnership collaboration, with most people (80%) mentioning one or two strengths. Only one person could not articulate any strengths at all.

Table 5: Number of strengths of partnership mentioned

Number of strengths mentioned:	%
None	1
1	58
2	22
3	9
4	4
5 or more	6
Mean score	1.9

Based on number answering: 69

Getting commitment from all partnership members was top of the list of strengths (39%) including the involvement of senior level members; establishing strong working relationships with clear shared priorities in the form of strategic direction

were also mentioned as strengths by 14% and 22% respectively. Good representation of partnerships / agencies involved (11%), effective leadership (9%) and ensuring alcohol issues are centre stage/ a focus (9%) were mentioned by a few people. Apart from those strengths, respondents offered a long list of various aspects of partnership working but each was mentioned by very few people (between 7% and 3%).

Open comments elaborated on the answers and indicated that some partnerships, at least, were seen to have evolved and strengthened over time:

“The partnership has been in existence for some years now, with continued development and revision of policies and protocols to avoid stagnation and promote growth. The partnership is active and reactive, adaptive to change and well managed.” (12)

The importance of achieving consensus regarding priorities and resource allocation was recognised:

“Growing confidence in decision making following significant work by the DAAT officers to bring partners to the table, pool funds, share objectives and achieve progress.” (16)

Equally, achieving a balance between the agendas and objectives of different member agencies was mentioned as one of the keys to success:

“Consensus around the high priorities, appreciation that resources will follow greatest needs and target risks; and that this will be balanced by ensuring minimum levels of service will be available universally.” (26)

Finally, the link with the national agenda and recognition of alcohol as an important issue was felt to have impacted on partnership working:

“You could say probably the national attention to alcohol helps. I remember starting off 4- 5 years ago. It was even harder then because people wouldn’t take you seriously when you said alcohol, so the national agenda, dialogue and media attention gives it” (58)

- **Weaknesses**

A wide range of weaknesses was also identified. Most people (92%) listed one or two weaknesses with 2 people (3%) unable to suggest any. Interestingly, comparing the means for strengths and weaknesses shows that respondents were able to list more strong points than negative ones concerning their partnership (mean score of 1.9 for strengths compared with 1.3 for weaknesses). Top of the list of weaknesses were financial constraints/funding (23%) and lack of resources or problems with allocating resources (20%). Problems of differing priorities, conflicting agendas and lack of strategic direction were mentioned by 18%. Again, there was a varied list with further weaknesses mentioned by only a few people (8% - 3%).

Table 6: Number of weaknesses of partnership mentioned

Number of weaknesses mentioned:	%
None	3
1	78
2	14
3	3
4	0
5 or more	3
Mean score	1.3

Based on number answering: 65

Quite a number of the reported weaknesses were summed up in one comment:
“Lack of financial resources. Inability of ‘the partnership’ to raise the profile of alcohol related harms. Silo working. Lack of focus. Lack of attendance. Lack of a vision to recognise that goals are best achieved by partnership working. Health versus criminal justice outcomes – i.e. the attitude of ‘well that’s health’s responsibility so health should do it’ rather than recognising that interventions can have cross-cutting impacts across sectors.” (90)

5.5 The challenges of partnership working

Despite the tendency towards positive rating of partnerships, the survey comments and the accounts of partnership working given in the key interviews highlighted the considerable challenges involved in partnership working.

Survey respondents were asked to say what their main challenges had been over the previous 12 months. All except one respondent had experienced some challenge. The main challenges reported are listed in table 7 and the issues raised are elaborated below under: funding and resources, gaining and keeping commitment, and developing shared priorities and goals.

Table 7: Main challenges faced by partnerships in past 12 months

Main past challenges:	%
Funding/securing funding for developing services / meeting needs/managing cuts	38
Lack of/safeguarding resources / human resources	35
Developing partnership e.g. getting commitment at right level, maintaining commitment, improve working etc	20
Lack of strategic direction / competing priorities / developing / implementing strategy	20
Performance managing /performance improvements	9
None	1

Based on number answering: 82

5.5.1 Funding and resources

Not surprisingly the main challenges focussed on issues involving funding and resources, such as managing cuts often in the face of increasing demands (38%) and lack of resources in general, but particularly human resources (35%).

“funding – lack of and timing. Regional funding either does not come or is given at the last minute, e.g. huge chunk in January to spend by end of March. Problems around funding for the alcohol co-ordinator post”. (76)

“We’re facing the increasing pressures on local authority budgets and we’re facing increasing and escalating need all the time – increasing admission to hospitals, younger people drinking, people with more entrenched problems” (24)

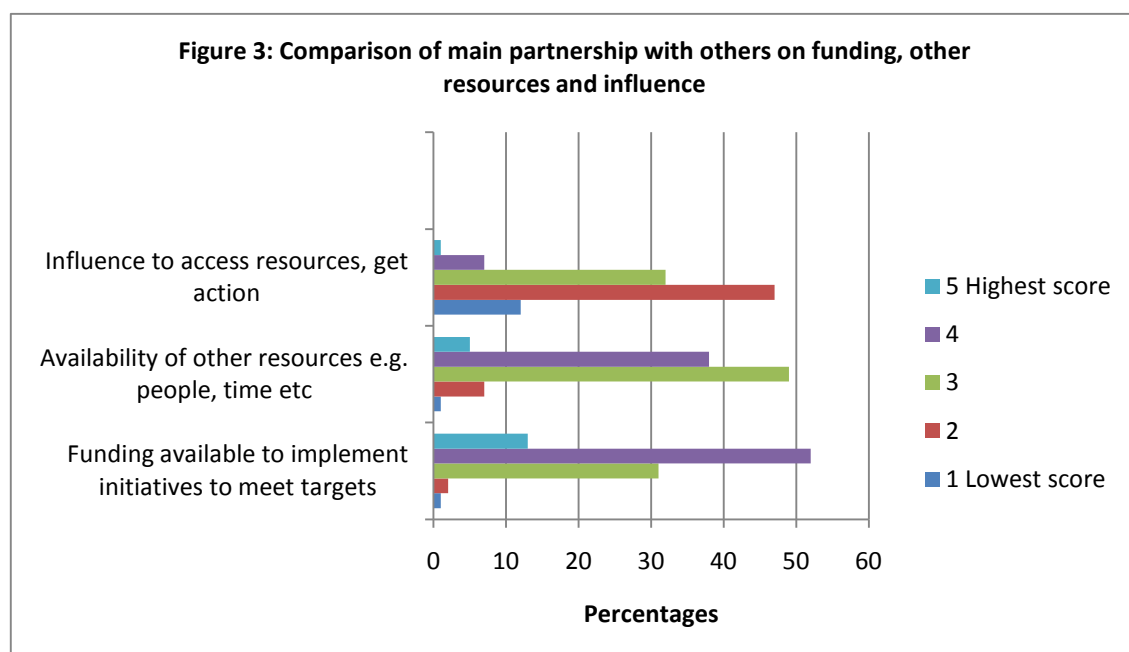
As mentioned in section four of the report, most respondents were involved in other partnerships in their areas. They were asked for their views on how their main partnership compared with other partnerships in the area in terms of: a) the funding available to implement initiatives to meet targets, b) available resources - staffing,

time and agency support - and c) influence to access resources and get action. The mean scores for these three dimensions are shown in table 8 below and the detailed scoring can be seen in figure 3. The data shows clearly that, although respondents appeared to be relatively happy with the way their main partnership was functioning, they were likely to feel that their resources and influence were less than what was available to other partnerships in their area.

Table 8: Mean scores, comparing partnership with others

Dimensions:	Means
Funding available to implement initiatives to meet targets	2.27
Availability of other resources e.g. people, time etc	2.61
Influence to access resources, get action	3.62

5=Highest score 1=Lowest score



N.B. Means and percentages are based on total number scoring each dimension

5.5.2 Gaining and Keeping Commitment

Another cluster of responses centred on challenges in developing the partnership, such as getting and maintaining commitment, particularly at the appropriate level (20%) Although respondents felt that their partnerships comprised agencies which were representative and relevant, they experienced a range of problems in securing the commitment of agencies and members to continuing, long term relationships. These included:

- the need to gain ‘top level’ buy in from senior people working in member organisations and agencies
- retaining individual members who are at the right level to access resources and take decisions within their own agencies
- securing agency commitment to shared goals and priorities
- sustaining a viable group over a period of time

The problems were well summed up by one key interviewee:

“partnerships will go through cycles, but in my view if you’ve got meetings - which is the main focus of partnerships - people only ... the only reason they continue to attend partnership meetings is either if they are getting something from it, or if they’re contributing something to it, ideally both. But if they don’t feel that either is happening, then either they stop coming, or the people that do come are those that are just wanting a quiet afternoon sitting having to do nothing.” (K8)

There were, of course, many other factors suggested as important for commitment, not least the need to convince partners that the cost of their time would bring benefits for their own agencies and organisations as well as support partnership goals and outcomes. An account from one key informant illustrates the problems and how they were dealt with in one area (Box 1). The account also indicates that satisfaction with a main partnership (e.g. the community safety partnership) may not be repeated with respect to a bigger strategic partnership or other overlapping partnership within the network.

Box 1

Top level ‘buy in’ and commitment from members in one local area:

At the top, strategic level of partnership, gaining continuing support was difficult:

You sit in a big CDRP meeting with very senior people, you know the chief executive, the borough commander and the director of public health from the PCT and they are talking about number plate thefts or something, you know fascinating, but you can almost see the director of public health thinking this is nothing to do with me, I should be doing something, I’ve got a million other things to do. And so I think what happens is, quite often they don’t turn up, they send a junior deputy and it becomes more difficult and certainly where I’ve been working in XX, it’s been very, the PCT has got a terrible reputation anyway, but certainly its contribution to partnership working is poor, or seems poor and probably is poor. So the statutory part, I say supposedly is delivering policy, but actually some of the partners are quite weak.

However, at a level where partners’ attendance was linked to more specific issues, commitment was much better:

If you take XX it’s famous for its partnership working around community safety. So they have a fortnightly tasking meeting where the data bods present an analysis of what’s been going on, where the hot spots are blah, blah, there’d be Licensing there, there’d be the CCTV people, there’d be the ambulance and police people there and they say, ‘ah that pub is causing a problem, CCTV will keep an eye on it’; licensing will go and do an enforcement visit and the police will call in and see what’s what and then that will be reported back. That way alcohol related harm is reduced there. So that is core business and that is going to go on whether or not there is an alcohol strategy. (K7)

Her experience of partnership working led this informant to conclude that, wherever possible, ‘themed’ partnership meetings were to be encouraged and were more likely to be successful.

Providing strategic direction, getting alcohol issues on to local agendas and helping to secure top level 'buy in' were all seen to benefit from having a local alcohol 'champion'. The role of the alcohol champion was well understood and valued. In one of the case study areas, the qualities needed were detailed as:

- Good communication - sending out information to partners – daily emails to partners, for example
- Good at facilitating consultations, making sure they happen and responding to members
- Good at keeping networks involved
- Constantly working to keep alcohol on the agenda –

“ So people like X, constantly, constantly, never letting it go away.....even without the political will...It was drip, drip and if there's political will now, then things could start improving.” (DAAT, team leader)

Box 2

The Alcohol Champion

So in our organisation she's always banged on about the importance of alcohol and she's been very astute I think at realising that working together about alcohol is going to be the sort of biggest issue and certainly in the local area I think we are a sort of a bit ahead of the game because of that driver really. She got the PCT involved and started badgering everyone so for us from day one we've had someone right at the top driving it down through the CDRP really.

What would happen if she wasn't there and she left?

I think it's ingrained so much, she's got it ingrained in the local strategic partnership, like it's the big issue for the local strategic partnership and (resources and funding are now being allocated to alcohol). It's drummed into the head of the guy who manages the crime and disorder reduction partnership about alcohol through her; so you know it's almost ingrained at every level of the organisation; but.... so I think the engine is running now and obviously there's the Xshire group to keep everything going and certainly in our locality, the alcohol locality group is sort of up and running and it's got the momentum behind it now. So I think things are going to carry on really in our area.

What makes her a champion?

With (name) she sort of knew that alcohol was quite a key issue and just from people like talking about it at that sort of level, but no one really taking hold,....with (name) it's a set of specific leadership skills.I think with any partnership at the start, it takes someone with good leadership skills who is willing just to go, “ right someone needs to sort this out, no one is doing it, so I'm just going to take up the mantel”; and you need to have someone who is quite driven in what they want to do and be quite confident, you know, ...until everyone goes alright yeah.. A lot of the time people want to work in partnerships but people don't want to do the extra work on top of their day job so you often need someone who is willing to get the initial momentum started. (Policy projects officer)

- *The role of the champion in gaining and keeping commitment*

In the past, champions had generally been committed individuals who had grown into a leadership position through their involvement and work in local areas. They could be seen as ‘organic’ champions evolving from local interaction and networking. Such examples were given by respondents. However, over the past decade, the term appears to have been adopted to describe a necessary role in setting up local structures and local strategies to tackle alcohol-related harms. The appointment of alcohol champions was mentioned frequently in questionnaire responses. This emerged in the course of the work and we were unable to gauge whether ‘appointed’ champions took on the role and executed it in ways similar to ‘organic’ champions. For instance, there may be a difference in the composition of partnerships around the ‘organic’ champion compared to the ‘appointed’ champion. Partnerships set up around an appointed champion, as part of a more formally structured system, may be more homogeneous in the types of agencies and individuals included than partnerships which evolve from organic roots. Concerns regarding the loss of a champion (as discussed in the example) are common and it may be that the appointment of a champion (an ‘official’ role) improves the chances of gaining and keeping commitment and setting up more permanent structures (as appears to be the case in the example above) and passing on the champion role.

5.5.3 *Developing shared priorities and goals*

Establishing shared priorities and goals proved a major challenge in many cases. For example:

“Agreeing the priorities and processes for reaching agreement around the deployment of the Area Based Grant in relation to community priorities. The process difficulties centred on removing old style ways of working and taking on a more accountable methodology and outcome focussed commissioning.”
(26)

Linked to this were concerns around establishing clarity of roles and responsibilities of both partnerships, agencies and individuals:

“The main weakness of the partnership has been holding individual agencies responsible for delivery – it can lead to a situation with cross cutting issues such as alcohol, that is the responsibility of everyone and therefore no-one”. (45)

Poor communication and a failure to share information were sometimes seen as sources of frustration which exacerbated the problems of coming to an agreement about goals and priorities.

In the end, what was seen as important – and often lacking – was the development of trust:

“It’s all about people. At the end of the day, it’s only about people isn’t it and it’s about whether trust has been established. In XX there has been a lot of angst in two tier environments where there has been a bid for unitary status - which failed; there has been a lot of angst between the district councils and the county council.”(K9)

“A big part of it is the building trust, you know two years ago we didn’t know each other and it’s taken, you know we had to build that relationship between ourselves and now you know that relationship is there and so you’ve built that trust up so the decisions, we know that if someone is going to say something then that is going to be delivered, because it’s a report back system as well.”
(Police inspector)

In trying to reach agreed priorities and goals, a number of elements of the challenge emerged from key interviews as particularly notable: managing large, complex partnerships; the institutional/ organisational context of the partnership; and tackling and changing professional cultures and ‘silo’ approaches. Themes touched on above – the development of trust, clarity of responsibility and accountability, the need to review professional ideologies and practices ran throughout the accounts of partnership working.

- ***Managing Size and Complexity***

Working with multiple organisations and partnerships within the same area increased the partnership ‘network’ and complicated lines of responsibility and accountability. A philosophy of ‘localism’, which devolved responsibility to local areas (accompanied often by more local level partnerships) meant that co-ordination of priorities and goals across the different partnership levels became increasingly time consuming and difficult. Here is an account given by one alcohol public health lead working in a large metropolitan area (Met-area, Box 3):

Box 3

Met-area: Managing partnership ‘networks’

Describing the formation of the partnership structure, our interviewee discussed the necessity of gaining engagement for the development of an alcohol strategy to co-ordinate efforts at various levels in this very large area:

We pulled this group together called the Alcohol Strategy Group for Met-area. It became very obvious after a while that basically they were bored as a group because they were sick of hearing about these little piddly projects that the councils were doing and they wanted to move somewhere and the group was dropping off considerably to a stage where people just weren’t turning up to meetings; they were sending their you know, not even their understudies, but their understudy’s understudy you know. It was getting to the stage where we were having just project workers turning up and I just said we’ve got to stop.

Eventually, with a lot of ‘hard selling’ there was success in setting up a Met-area Alcohol Strategy Group which “justified our existence” and had a new structure for policy implementation. This took approximately one year. The structure included multiple smaller partnership groups:

... basically underneath here, each one of the boroughs has their own alcohol strategy group. Each one of their own boroughs has their own CDRP, each one of their own boroughs has their own commissioning structure and it’s about all of these people who are involved in all of this, what’s going on at grass roots level.

With only one alcohol public health lead, this presented problems of communication and leadership:

So to be honest, each one of these (members of the top level strategic boards), they have their own, they have Met-area wide meetings, but they also have their local meetings. So if I was just to go to the three meetings there, that's another three meetings in my diary that I can't fit in, but if we were actually trying to get these all on board and singing at some point, we'd have to go to each one of these on a local level, to try and get them on board... so that's 33 meetings that I've got to go to. It's physically impossible. There is only me and the capacity of only me, I can't go to each one of these meetings across the all the boroughs.

I think the chief executives ... if you're a chief exec of a PCT or a local authority, alcohol is probably this much of your job (*makes a sign to show a very small amount*). So they may do a one line or a two line statement in a meeting and we expect that that is the end of the discussion and it's gone down the line. Then what happens is that it goes down to the director's or officer's level and they start having these huge debates, that we've had with the chief executives, to get them on board, but without actually us there to have that discussion with them.

Due to a lull in activity during the election period in 2010, an action plan had been proposed to address this problem:

The way we are going is we've got an action plan and, because the CDRPs will have probably most people on there - probably not planning - but they'll have licensing and trading standards, community safety, on the CDRPs, is to actually go and attack the ten CDRPs and we are going to visit every single one of them (K17)

- ***Institutional/ organisational context***

According to several accounts, the emphasis placed on alcohol issues and the level of priority accorded to alcohol was at least partly dependent on the institutional embedding of the partnership. As one interviewee explained:

"I think what's interesting for us is where the alcohol strategy fits, because obviously if the alcohol work is housed, or hosted by the DAT, then it would tend to feed up to the CDRP. A lot of alcohol work sits within the PCT in Xarea for example and in Yarea.

That's under the health and well being?

Actually it would probably still go up to the DAT but there'd be much more of a health, the links to health would be much stronger just because somebody is physically employed by the PCT.

So that's important- where somebody's employed, where they are housed can have an effect?

Yeah just by dint of the team meetings you go to, the phone calls you are overhearing." (K7)

Another key informant gave this example of finding the right 'home' to ensure that the alcohol strategy would be implemented (Box 4):

Box 4:

Finding an appropriate organisational base and negotiating priorities and ownership

.... so it took a long time to write it (alcohol strategy) because of partnership difficulties really and where was the ownership. The DAT, we were part of the DAT, but to be honest that never really worked because there was something on the DAT Agenda each time for alcohol but it never got to that bit. there were huge issues around drug treatment and everything in the city so it never really got on there. Although the individual DAT members would have said alcohol is a more serious issue than drugs for us but our remit has to be this and that's what we have to spend our money on. ... When the Alcohol Harm Reduction Strategy was published, which said you should have DAATs, then I took it back to them and said look this says.. and they said well we'd like to be a DAAT, but to be honest we don't want to do that because that would assume we were going to be able to do something and we cannot see anyway to spend any money on alcohol, so we think that would be a deception.....So we shifted it to the newly formed CDRP which then became Safer XTown and there were people in public health who were concerned about that move, seeing it as a very crime orientated organisation. I took the proposal to the CDRP before it became Safer XTown and looked at all these policemen around the table and said look if we are going to do this then I have to say that health is really our major concern and we must not lose this from the agenda and they agreed that.

The clash between powerful organisations/agencies working in the same area was reported as one of the difficulties in this city.

It is a difficult city to have effective partnerships working because you've got big beasts within it and you do have a certain amount of antipathy between local authority and the health services. So when the new PCT was formed, the idea was that the Director of Public Health would actually sit in both organisations, but that hasn't happened and I think it is, I think it's an unenviable task anyway to do that job in this city if you were sitting across both organisations, goodness knows how you would ever get any sleep really. (K08)

- ***Professional cultures and 'silo' approaches***

A major issue running through the interviews was the problem of changing professional behaviour. This was linked to issues of institutional and organisational context (discussed above) which 'embedded' individuals within particular occupational or institutional cultures with associated values and ways of working. There was doubt about the extent to which partnership working could overcome long established behaviours:

"I am not convinced as to how far the partnership will be able to influence behaviour and action of partners, especially if this means changing what they do now. However time will tell!" (56)

And there was recognition that partners needed to be convinced that change was to their benefit:

“...partnership is easy to say but very difficult to actually do, because it requires behaviour to change, to engage with people and to put your money where your mouth is, basically. it's about getting the right bit at the right level and then getting buy in appropriate to that level..... being clear about what needs to be done where and engaging with people..... actually, unless it was going to, unless we were going to change the culture of GPs or clinicians or of nurses, we weren't going to actually change the price of eggs....So it's about being able to look at it along that spectrum of deliverability and making a difference to somebody's day to day working. You know, why would they want to invest their energy in doing something new, unless it's going to deliver a change for the better? So it's trying to plug into all of these different levels and press the right buttons along that continuum” (K9)

Arising from the restrictions of institutional and professional pressures was a strong tendency towards 'silo' working – despite the reigning philosophy of joint working and shared priorities and goals. Many of the comments reflected the view that current systems and structures for the delivery of policy still channelled individuals and agencies into 'silos' which made partnership difficult. One example of the problems and an attempt to solve them came from interviewees working in a partnership between the local council and police at electoral ward level. (Box 5)

Box 5.

Breaking down professional 'silos' – Training

Interviewees in this partnership commented on the need to break down the insularity and silo working of former times. They spoke of a sea change in how issues were identified and how partnership working fostered the acceptance of joint responsibility for problems within the partnership as a whole, in contrast to the blame culture which had historically prevailed. Eradicating a blame culture allowed commitment and mutual trust to develop more readily and this was needed to foster effective ways of working. Training offered one approach to breaking down 'silos'. The principles of partnership working at neighbourhood level, for example, were now embedded in routine police training.

“New recruits get trained in the model. Whereas new recruits always previously went to the response job - which is the 24/7 answering the 999 calls - new recruits now come into a neighbourhood policing team and they might go to response at a later stage. But they come here to get embedded in the neighbourhood policing team principles and ethos before anything else. And that whole partnership thing, which is really difficult to grasp isn't it, that thing about 'oh so what's our responsibility?' and it's actually about partnerships and that is kind of something that you do at training. It's embedded. I mean, for 22 years I was a response officer at differing ranks and I probably had never spoken to anybody from X council, to try and sort out anything, I had just gone to 999 calls”. (Police inspector).

Nevertheless other respondents who were part of the same partnership noted that, for some members, the rigidity of their own agency's agendas and close monitoring procedures hindered their ability to be flexible and responsive and this prevented greater commitment to working in partnership

Another example highlighted the issue of managing the imbalance of power (or perceived power) between professional groups. Although this was rarely mentioned directly, partnerships are faced with countering traditional professional hierarchies and the possible dominance of some professional groups (e.g. doctors) over others (e.g. nurses). In the case discussed in box 6, partnership working required shifts in the balance of power between senior police officers – responsible for securing resources - and youth workers who were responsible for delivering the project.

Box 6

Power issues

In order to work sensitively and effectively in engaging young people in a local project in one rural area, the police needed to relinquish their traditional ways of working based on an enforcement perspective and take the lead from youth services. Working within a youth centred approach evolved progressively and required adaptability on their part. Through trying to establish common ground, the project afforded partners the opportunity to develop more effective working relationships. Building up mutual trust was essential and took considerable time to allow for increasing understanding of each agency's work ethos, roles and responsibilities. Several participants noted that attitudes had changed as understanding of perspectives had improved, protocols had been established and compromises and their impacts were explored. The dilemmas faced in marrying very different models and working practices were commented on by a youth worker on the project:

“Initially I think when the project was set up both staff and young people were very sceptical because- how can you work with enablers and enforcers together? ... but because of the work, I suppose, and the commitment of the partners in terms of actually going outside of our briefs a little bit (the problems were overcome), in terms of when the PCSO (Police Community Support Officer) is there, they are actually working under the direction of youth work principles and under the direction of youth workers. They are not in their PCSO capacity for example. And so that's taken quite a bit of time for us to work that out and trust each other, do you know what I mean? Because initially the police were kind of directing people to this space - then the young people almost felt corralled - which then creates issues and tension.”
(Youth worker)

- ***Shared priorities and goals***

While agreeing that a common set of priorities and goals is a pre-requisite of effective partnership working, the above sections illustrate well the hurdles partners face in trying to achieve that aim. It may be that as partnership networks grow and become more complex, the problems will be greater rather than fewer. As we have seen, issues of trust, conflict between responsibility and accountability to the employing agency and to the partnership, and the diverse training and professional experiences of members may prevent fully integrated partnership working, even where there are good intentions to move in that direction.

5.6 Conclusion

The wider research literature has generally found support for partnership approaches to policy delivery and the findings from this research suggest that in the alcohol field a culture of partnership working has become accepted as 'normal', a rational response to coping with complex problems which require complex solutions. The trick is to find ways of ensuring that partnerships are a successful mechanism for policy delivery. A considerable degree of thought has been put into the principles and guidelines for building, running and sustaining effective partnerships. Wildridge *et al.* (2004: 7-8), for example, cite research conducted by the Wilder Research Centre which identified 20 'critical success factors' for partnership working. These are:

Environment

- history of collaboration or co-operation;
- collaborative group seen as a legitimate leader;
- favourable political and social climate.

Membership

- mutual respect, understanding and trust;
- appropriate cross section of members;
- members see collaboration as in their self-interest;
- ability to compromise.

Process and structure

- members share a stake;
- multiple layers of participation;
- flexibility;
- clear roles and policy guidelines;
- adaptability;
- appropriate pace of development.

Communication

- open and frequent;
- informal relationships and communication links.

Purpose

- concrete, attainable goals and objectives;
- shared vision;
- unique purpose.

Resources

- sufficient funds, staff, materials and time;
- skilled leadership.

Partnership working in the alcohol field clearly meets similar challenges to those encountered more generally in health, criminal justice and social welfare domains. Many of the 'critical success factors' listed by Wildridge *et al.* (2004) emerged from the survey and from key interviews as both facilitating factors (when they worked well) and constraints (when they did not work so well). What the research has highlighted, is that the rapid growth of partnership approaches has resulted in a complex network of inter-linked, overlapping and 'nested' sets of partnerships and that partnership structures and interaction are still evolving and changing. This might lead us to question the apparently taken-for-granted value placed on partnership working as an appropriate model for service delivery. Indeed, some respondents did

propose that more consideration was needed regarding the function of partnerships. Partnerships, it was suggested, should identify and concentrate only on actions and activities that required joint working; not on actions that are core business or are already done by someone else:

“...*what we do in partnership is only what we can't do on our own.*” (local authority officer)

In other words the partnership has *to add something of value* and this was seen as important for all partnerships at whatever level they operated. A PCT respondent described how a recent review of their action plan by the Community Safety Partnership Alcohol Group had narrowed down the plan to focus only on actions that required partnership working. They had spent time separating core business out from what needed partnership working and the result was a streamlined action plan. This appears to reflect a degree of learning as partnerships mature: there is more trust, better understanding of the issues, of each others' roles and responsibilities and what is required to be done (and by whom).

6. Case Study: Partnership working in an area with non-coterminous boundaries

6.1 The challenges of working across non-coterminous boundaries

Earlier research on partnership working has highlighted the challenges of working in areas with non-coterminous boundaries (Perkins *et al*, 2010; ODPM/Department of Transport, 2006). An Improvement and Development Agency (IDeA) and Office for Public Management (OPM) support programme for two and three tier areas found that the challenges clustered around three sets of issues: size and complexity, functions and perspectives and politics (IDeA, 2009).. Whilst acknowledging that partnership working is complex per se the IDeA argue that for two or three tier areas the degree of complexity is considerably greater. This complexity results not just from the different layers of local government but also from the multiple partnership structures that arise from this. The IDeA highlight that addressing cross cutting issues –such as reducing alcohol related harm – requires joint working between local authorities and their partners; but authorities in two/three tier areas may have different perspectives on an issue and different approaches to addressing it. Finally, political tensions between political parties and groups and between authorities can create challenges. Whilst these three sets of challenges can exist simultaneously, the IDeA found that, as two/three tier areas move from planning to delivery, the nature of the challenges they face in partnership working tend to shift. In the early stages, challenges often relate to size and complexity e.g mapping out current activity, identifying partners. As partnership working progresses and partners start to think about what new activities and services might be needed then differences in their perspectives on issues may come to the fore. As plans and talks move on to commissioning and funding new initiatives (or possibly decommissioning others) then issues around organisational and party politics tend to become apparent.

Within this study, it was evident quite quickly from the survey data that for those professionals striving to reduce alcohol related harms, working with non-coterminous boundaries further complicated an already complex working environment. In order to explore the issues further a case study was conducted in one such area. To preserve anonymity, pseudonyms have been used and the following profile is general in nature (e.g. does not include population statistics, alcohol related harm data etc).

6.2 The local context

‘Pan-Xshire’ covers a large geographical area of England and incorporates the administrative County of Xshire, comprising twelve district councils, together with two unitary authorities..

The Xshire County Council (XCC) is a two tier local authority area comprising Xshire County Council and twelve district councils: this will be referred to as Xshire.

The pan-Xshire area encompasses some of the least and some of the most deprived areas in the country and this social and economic diversity is reflected in the health experience of the population with persistent health inequalities between different groups and areas. Recent analysis highlighted the ten largest gaps in health outcomes

between the most and least deprived populations within Xshire. For example, people from the most deprived areas are eight times more likely to die prematurely from liver disease than those in the least deprived areas.

There are five Primary Care Trusts (PCTs) covering the pan-Xshire area: 3 covering the County of Xshire and one in each unitary authority.

Xshire Drug and Alcohol Action Team (XDAAT) is a county wide agency and it does not include responsibility for the two unitary authorities. XDAAT oversees the operational delivery of services within the three broad sub-regions which match the PCTs footprints for the areas of Xshire. Each unitary authority has its own DAAT and in both unitary areas the DAAT is part of the local Community Safety Partnership.

There is an Xshire County Council Joint Health Unit which was established to bridge the gap between PCTs and the County Council. This is headed by a Public Health consultant who works very closely with the Directors of Public Health (DPH) in the three PCTs within the County footprint.

There are a number of pan-Xshire Public Health networks, including one for alcohol – the Xshire Alcohol Network (XAN). The key purpose of these networks is to support the PCTs and the broader public health system in the delivery of health improvement and the reduction of health inequalities across the pan-Xshire area. XAN was originally part of a larger network covering two counties but this was felt to be too large a network (geographically and numerically) and so they separated. XAN focuses on co-ordinating work across agencies, sharing good practice, lobbying on issues such as a minimum price for alcohol, and securing resources for alcohol related projects. Funding was found for an XAN co-ordinator (this funding has since come to an end). XAN is chaired by a police officer and there was a conscious decision not to have a ‘health’ Chair to help ensure balance and prevent XAN from being too public health dominated.

At the time when this research was undertaken, the county of Xshire had chosen NI39¹ as one of its county wide targets in the Local Area Agreement (LAA). The above outline illustrates the complex structures within which partnerships operated. For those professionals striving to reduce alcohol related harms, working with non-coterminous boundaries further complicated an already complex working environment. The following sections report the key themes which emerged from the interviews; for clarity they have been separated but they are interrelated in many ways. The four issues which emerged most clearly were: duplication of effort, problems of decision making, commissioning, the tensions arising from multi-level governance.

6.3 Key Themes

6.3.1 Duplication and overlap

The presence of different ‘footprints’ - i.e. PCT, district, county - means that there can be a tendency for partnerships to proliferate with each one covering its own footprint. This can lead to duplication of work and an increasing number of meetings; people who have a county or pan Xshire remit (e.g Trading Standards) are frequently

required to attend numerous meetings of similar groups in all the different parts of Xshire. Such duplication was regarded as both unnecessary and burdensome. The problem was compounded by the instability which resulted from frequent restructuring of organisations. As one alcohol lead told us, footprints are not fixed and institutional reorganisations can result in 'new' footprints. For example, several years ago PCTs were merged, and he explained that:

"...it did use to feel much simpler... I was responsible for one local authority so there was one council to deal with...we now cover four local authorities and that transition, although I think it's working, it's been challenging as well because all of a sudden when you are used to working with one local authority you've got four and all the partnerships that come with those four local authorities, there's duplication, there's quite a bit of duplication....with the crime and disorder partnerships so whereas we once worked with one, we now work with four" (Alcohol lead)

Furthermore he reflected:

"Then we've got the Xshire level which again you've obviously another set of partnerships at that level."

The merger of the PCTs provided a good example of how duplication could occur. For example, the merged PCT tried to establish an Alcohol Strategy Group to cover the new PCT footprint; they wanted to develop a joint alcohol strategy and action plan for the enlarged PCT. Although they did get the different areas to work together, they did not manage to secure agreement - the result was two strategies and two plans for the PCT (and for those working at PCT or county level two sets of meetings to attend). A key sticking point was that one area felt it had specific issues which might have got 'lost' in a joint strategy and action plan. This highlights the importance of the perceived threat to local relevance when areas are required to work together towards a common goal.

Similar issues regarding loss of local relevance were reported to have influenced Local Authority actions and approaches to partnership working. A recent merger of two Community Safety Partnerships and their related alcohol groups had illustrated the difficulties. The two local alcohol groups contain many of the same partners, shared a strategy and action plan and were concerned about the same issues. So a merger made 'sense' from the perspective of those attending two sets of meetings. However, the decision had to be taken at senior level - and from the local government perspective, there were reasons why it may have been seen as preferable to keep the two alcohol groups separate and local.

"...as local authorities we want to work in partnership ... but it's just the fact that we are organisations run by councillors who represent the local constituencies and obviously what they want to do is ensure that their authority is delivering outcomes for their communities really as opposed to you know them sending officers and money is being spent across the patch when whose money is it ,is there any money going in?.So (A) council say, like we've got £10,000 and we are going to give it to the alcohol group to spend against our priorities and that is a Central X-shire group, there's a worry that that cash which is essentially for (A) council residents just sort of gets lost."
(LA Officer)

The advantages and potential savings of mergers were recognised; as one respondent noted: “.....no organisation now can afford to have people attending pointless meetings”. There also appeared to be a consensus that communications and social marketing could be done much more cost effectively over a larger footprint. Public health networks (like the XAN) operating on a county or pan-Xshire level were increasingly seen as a key means of delivering health campaigns, either by developing resources which could be used by local areas or rolling out a campaign across a larger footprint (eg PCT, county).

6.3.2 Decision making: Making the ‘right’ decisions at the ‘right’ level

Decision making was described as a ‘murky issue’ for partnerships in two tier authorities. Respondents stressed the importance of making the ‘right’ decision at the ‘right’ level, but felt that it was not always possible to identify the most appropriate level. For example, if resources were involved it was argued that the decision on how that funding is spent should be made at the level that the resources are held, e.g. if PCT funding, they should decide as they are responsible and accountable for those funds. However, there were concerns that some groups felt they could spend or direct the resources of other groups. Given the pressure on resources, this could create tensions. Respondents felt that these tensions could be reduced by having clear decision making structures and ensuring that the ‘right’ people were around the partnership table. The ‘right’ people were thought to be those who were senior enough to have the authority to make decisions - but not too senior (e.g. Chief Executives). Individuals at the level of Chief Executive were likely to have an overview (i.e. knew the issues), but they were unlikely to be aware of the nuances (e.g. what resources were available ‘on the ground’). However, the ‘buy in’ of senior staff was viewed as crucial in the decision making process. Thus, involvement of decision makers at an appropriate level to represent the different authorities entailed an important balancing act.

6.3.3 Commissioning

X-shire was in the process of re-commissioning and modernising its drugs and alcohol services for the county of Xshire, with each of the three PCTs being re-commissioned in turn. XDAAT was the commissioner for drug services (and substance misuse services for young people) but for alcohol both XDAAT and PCTs had commissioning roles for services for adults. Prior to modernisation, although XDAAT had an alcohol remit, it had not played a substantial role in the commissioning of alcohol services. The restructuring taking place at the time of this study was changing this situation. A key reason for re-commissioning was the piecemeal nature of the existing services which had evolved over time, been commissioned over different footprints and were not universal even across PCTs, so that:

“There were a lot of organisations, a lot of duplication, a lot of uncertainty both from clients and from prospective referrers about who people should go to...people (were) not getting the full range of services depending on where they entered the system, because agencies didn’t necessarily work with each other as well as they might have done” (DAAT officer).

In some areas there were long waiting lists for those wishing to access services. One of the underpinning principles of the modernisation was the establishment of an integrated drugs and alcohol treatment service. The intention was that, in the future,

drugs and alcohol services would be jointly commissioned but not necessarily jointly delivered, with services continuing to be provided in a variety of settings by one provider (or a lead provider and partners).

Creating appropriate governance and reporting structure for the new system presented a number of challenges. XDAAT had a DAAT Partnership Board and three locality commissioning groups on the PCT footprints which dealt with drugs but not alcohol. In addition, there were a number of alcohol groups some of which, but not all, were based on PCT footprints; so in effect there were parallel drugs and alcohol groups.

The plan was to create an integrated governance and reporting structure within the DAAT structures. However, concerns had been raised, particularly from the public health perspective, that the DAAT, given its treatment remit, would focus on treatment (especially dependent drinkers) and insufficient attention would be paid to prevention or the broader context (e.g. licensing, community safety etc). Having spent time building up links with a broad range of partners, there were worries that these links might be lost if treatment was the prime focus of alcohol groups.

Underpinning these debates were fundamental questions regarding approaches and responses to alcohol. Tensions seemed to exist between XDAAT and the PCTs and XAN, with some respondents arguing that XDAAT had a unilateral desire to 'control alcohol' within X-shire and that this would lead to a narrowing of approach and XDAAT maintaining that it was a legitimate role and it was one taken on by many other DAATs in England.

Clearly, issues around commissioning are linked to fears of loss of resources and funds, issues of de-commissioning of services where mergers are taking place and setting priorities across authority borders. There may, too, have been elements of the wider debate around the allocation of resources to drugs at the expense of alcohol and concerns that increasing XDAAT's role in alcohol might result in a less comprehensive prevention and treatment response.

6.3.5 Multi-level governance: tensions and practicalities

Alcohol was identified as a priority at all levels of governance and by a broad range of organisations working at different spatial levels. The 'layer' of working that was seen as most difficult was the pan- Xshire level as it included two unitary authorities as well as the County Council; moreover, the political dimensions were seen as a further complication. The Xshire Alcohol Network (XAN) operated on a pan-Xshire footprint and was funded from a variety of sources (mostly county council, but also region, PCTs) but these funding sources were not guaranteed and could vary from year to year. Questions arose about who puts money in and what they wanted for their money.

For example, region funded XAN to work on HICs (High Impact Changes, relevant to health outcomes)² and some of the County Council funding was for community safety. Given that a substantial amount of funding derived from XCC and that the XAN action plan was seen as the lead for the County Council Local Area Agreements (LAA), there were concerns that the XAN could be 'sucked into' being a *county* rather than *pan-Xshire* network, with the unitary authorities not being fully included

and thus creating inequalities. However, respondents felt that within partnership working in Xshire in general there was a drive for working at the pan-Xshire footprint and to include the unitary authorities.

As mentioned above, issues of localism emerged as a strong source of tension. Whilst some district councils had put alcohol high on the agenda many respondents felt that district councils were really only interested in their 'own patch' and did not perceive themselves as part of the 'bigger' picture. As a consequence they were seen as not interested in the PCT, Xshire or pan- Xshire footprints. Whilst respondents could, to an extent, understand this approach and the pressures of local democratic accountability, they nevertheless found it frustrating. For example, district councils were often under pressure from their elected members to act quickly to address local issues. Other respondents felt that this 'fire fighting' approach could hinder attempts to develop a more coherent and co-ordinated approach over bigger footprints (e.g. PCT, county).

In relation to the delivery of NI 39, the district councils argued that there was only a limited amount that they could do. NI 39 is part of the LAA which is set and owned by the County, each of the 12 district councils have a target for NI39 but NI 39 is 'owned' by the PCT which covers more than one council, so as one respondent noted you had a situation where:

"(the PCT) are working to reduce NI39 over four council areas. The councils are interested in reducing it in their one area and county are obviously interested in it coming down on a X-shire area level..."

But that

"...it just gets complicated in knowing what you're delivering against and you know I suppose things like national indicators... we are delivering against National Indicator 39 for example but that technically isn't a district council target and as a district council there is only a limited amount we can do to have an influence on how that, the rate of that target. So we need to work with the Primary Care Trusts or the Primary Care Trusts work with us more likely on that target for example. And obviously we can only sign up to a certain amount, you know to say we can only deliver on our local footprint effectively, but obviously we can help a certain amount, but they've got a different target than we've signed up for, so it's a bit difficult.

There was an acknowledgement that the NHS can not deliver its targets without the cooperation of the local authority and vice versa. But as the comments above show, there were considerable problems in reaching consensus on issues such as targets, priorities and accountability and these were exacerbated by the lack of co-terminous boundaries and the need to work with partners at many different levels.

6.4. Conclusion

The problems of joint working in non-coterminous areas, discussed in the IDeA (2009) publication, are clearly illustrated in this case study. While increasing size and complexity of networks present challenges for all partnerships, the lack of coterminous boundaries and the growing shift towards localism in the development of policy, strategies and service delivery, may mitigate against effective partnership working. Partnership working requires, at the least, agreed aims, targets and priority

setting and, as we have seen above, agreement on the roles and functions of the different partners. These agreements become more difficult to reach where there are multiple layers of authority, accountability and lines of management, and where there are different, competing political pressures on decision makers. Rational models of service delivery, which may require mergers between partnerships and service providers, are likely to raise concerns which reveal ideological differences regarding the appropriateness of responses to alcohol and practical fears regarding the possible impact on service commissioning and the survival of agencies.

Notes

1. NI39: This is a target aimed at reducing the rate of increase in alcohol-related hospital admissions. In 2007, as part of Public Service Agreement (PSA) 25, aimed at reducing the harm caused by alcohol and drugs, an indicator was introduced (PSA 25 Indicator 2) which measures the number of alcohol-related hospital admissions (ARAs). The aim is to reduce the trend of increasing hospital admissions. Reflecting this PSA, the Vital Signs Indicator 26 (VSC 26) introduced in 2008, measures the variation in the rate of alcohol-related hospital admissions. National Indicator 39 (NI 39), one of the 198 Local Authority indicators jointly owned by local agencies, also measures the rate of alcohol-related hospital admissions. The Vital Signs Indicators were introduced at three levels of priority:

- tier 1 – national requirements (where there is a national target or commitment, such as waiting times);
- tier 2 – national priority for local delivery (where there are differential targets for PCTs – such as reductions in mortality which vary according to baseline); and
- tier 3 – for local action.

While tier 1 and 2 indicators are overseen by the Strategic Health Authority and the Department of Health, tier 3 indicators are not. VSC 26 was included as a tier 3 indicator and was therefore in the lowest priority group. Nevertheless, approximately 100 of the 153 PCTs included VSC 26 in their operational plans and, as a consequence, set themselves targets for reducing ARAs. Considerably fewer areas had NI39 included as an interagency target within their Local Authority Agreements – approximately 60 PCTs.

2. HICS: The Department of Health identified seven 'high impact changes' (HICs), which it argued would be the most effective actions for local areas to take to reduce alcohol-related harm. The 'High Impact Changes' are: 1. work in partnership; 2. develop activities to control the impact of alcohol misuse in the community; 3. influence through advocacy; 4. improve the effectiveness and capacity of specialist treatment; 5. appoint an Alcohol Health Worker; 6. identification and Brief Advice (IBA) – promote more help to encourage people to drink less; 7. amplify national social marketing priorities. HICs 4-7 are evidenced based interventions, whilst HICs 1-3 are 'enablers', with HIC 1 'work in partnership' identified as a key building block for success (DH, 2009).

7. Case Study: Rural Issues

7.1 The rural context

Responding to increasing criticisms of the decline in rural facilities and access to services, the Rural White Paper (2000) introduced the concept of ‘rural proofing’ in an attempt to highlight how policies, services and resources should be systematically considered and developed in response to the needs of people living in rural areas.

However, defining what constitutes a rural area has its challenges; for example, there is no straightforward correspondence between rural acreage and population size, density or land use. This was the situation in the area in which our case study was carried out. Because the District has a Metropolitan Council, the whole of the area, urban and rural included, has in the past, been classified as ‘urban’ in official documents, with a tendency for rural areas to be marginalised. This has resulted in focussing policies, services and resources towards the needs of the urban majority at the expense of those in rural areas.

The case study District has a significant city hub with extensive rural areas bordering it; these make up about two thirds of the land area. The majority of the population live in urban areas with one in five of the District’s population living in the relatively large villages, market towns and more dispersed settlements within the rural areas. The District as a whole has a considerable ethnic mix and a mix of affluent and deprived areas.

In the case study area, the main partnerships spanned both urban and rural populations. Thus, they were faced with responding to the issues outlined in the Rural White paper (2000) and still balancing the needs of urban and more rural areas.

7.2 The partnerships

The Local Strategic Partnership was the ‘umbrella’ under which there were a number of partnerships, sub-committees and groups:

- the Safer Communities Partnership (SCP) – which included the Drug and Alcohol Team for the area, and
- the Safer Communities Strategy Group (concerned with strategic decision making) and
- the Executive Group of the Safer Communities Strategy Group (monitoring of the Strategy group).
- the Joint Commissioning Group for Substance Misuse (drugs and alcohol)
- The Alcohol Strategy Group (part of the Safer Communities Strategy Group), responsible for overseeing the development and implementation of the alcohol strategy. It performance manages the partners to deliver against its aims and objectives. It has a very broad membership including strong representation from the Council; licensing; different area forums, committees; social marketing representatives; adult services; youth services; youth offending team; children and young people and commissioners; education; trading standards; housing and substance misuse; fire service and also police; police licensing; probation; health,

including practitioners such as GPs, clinical leads etc; public health; service user representative forum.

- Other partnerships linking in to the Alcohol Strategy Group at district level include themed groups such as children and young people; health and wellbeing; various drug themed groups; and other forums, such as licensing and service user representatives.

The Alcohol Strategy Group covers the whole of the District and case study interviews were held with representatives from this group as well as with individuals involved in more local level partnerships.

7.3 Evolving partnerships at local level

While partnerships on the whole had been imposed top down on working structures and relations, at the grass roots level practitioners had generated a number of new partnership initiatives to serve rural needs.

One example was provided by respondents working jointly within the statutory and voluntary sectors; they described how a new partnership had evolved in a rural part of the District. At a substance misuse service providers' meeting, representatives began looking at potential shared bids and clinical and developmental work but within a smaller rural footprint than a partnership serving the whole District. At the time of interview, the new partnership was developing governance and leadership and working to put in joint bids, and a partnership structure was beginning to emerge.

The voluntary service provider mentioned in the example above tended to work with a number of different partners rather than in a specific partnership group. Links with primary care and the local DAAT were close and connections had been set up more informally with a wide range of agencies, for example with housing and probation. While decisions were usually made collaboratively with the local DAAT partnership, the voluntary agency was forceful in pushing for what it saw as important for service users and it offered considerable flexibility to meet user needs. The voluntary service provider had initiated a local 'satellite' partnership group (in a rural area), alongside the equivalent at District level. This development appears to have been for strategic reasons to help secure resources which might otherwise have been directed elsewhere. The new 'satellite' partnership was able to develop without additional funding because a service manager from the voluntary agency had taken on the role of an informal champion. With the partnership structure in place the voluntary agency secured representation at weekly meetings of the local Community Drug and Alcohol Team – something which they had aspired to for a considerable time:

“It's something that we've struggled with for years and years and years at X agency and it's Y who attends those, who is the service manager, and when she came into post, she was kind of like a dog with a bone really and she wouldn't let it go because she knew how important that was and so she would repeatedly, repeatedly push for it.” (Service manager)

Within the criminal justice partnerships, Ward Officer Teams (WOT) had recently been developed as a mechanism to tackle 'crime and grime'. They operated at electoral ward level and were joint partnerships between the local council and police. The WOT included children and youth services, neighbourhood support services,

ward co-ordinators and area development officers and, depending on the issues identified as local priorities, may also include cleansing, traffic and fire services. Their aim was to bring together information and intelligence about specific local concerns, to secure and direct resources towards these issues within a six week timeframe and to enable services to work together. Alcohol is likely to cut across many of the issues with which they were dealing and a visit to one WOT in a rural area was undertaken to explore some of the issues around alcohol, how these were perceived and addressed.

The above examples illustrate yet again, the complexity of partnership working in general and the multiplicity of collaborative effort at different levels.

7.4 Themes

Many of the themes emerging from the interviews were general to partnership working and were similar to themes discussed elsewhere in the report. In this section we will highlight only the main points discussed regarding partnership working in areas which include a large rural element:

7.4.1 Perceptions of affluence and deprivation

While the District was generally known to have very high levels of deprivation, the more rural parts were often portrayed as affluent. Yet some of the rural towns and outlying settlements were deprived although located within a more affluent hinterland. Alcohol problems occurred in both affluent and deprived areas; but they were more likely to be concentrated and visible in more deprived rural settlements. For example, young people were more likely to be seen drinking in public places.

Despite attempts to counter the focus on urban need with the concept of 'rural proofing' it was acknowledged that the underlying challenge of working in a metropolitan district with relatively high levels of deprivation inevitably meant that rural issues would not be prioritised.

"I think in terms of alcohol I think what you'll find will come up everywhere is a total lack of funding. So consequently you end up putting your resources where the biggest problems are basically." (Alcohol commissioner)

Local conditions in rural areas made effective responses to alcohol problems more difficult. With regards to services in general, respondents often commented on the overall lack of services and infrastructure to support local residents living in rural areas. The closure of schools, post offices, shops and leisure facilities (as documented in the Rural White Paper, 2000) presented a particular disadvantage for people dealing with or recovering from alcohol problems; having readily accessible services and leisure activities was felt to be important in offering them alternatives to the familiar behaviour patterns typically associated with their drinking habits.

"....As people recover there are more support things they might want to do or more activities or hobbies or interests .And there is no kind of stepping stone. And I think as well further out in the outer communities, if the schools and the shops and the post offices have gone there is still the pub and that's you know...That is where they drink as well." (Drug and Alcohol Team Leader)

7.4.2 Impact of a rural location on service provision and use

It was universally acknowledged that putting services into rural areas was expensive and that rural areas were underserved by treatment and support agencies. Community outreach clinics, mostly operating out of GP's surgeries, and home visits had evolved to deliver treatment to the smaller villages and more dispersed rural communities. Although treatment delivery was not uniform across the District, all GPs had signed up for IBA (Identification of alcohol problems and Brief Advice) targeting new patients through opportunistic screening. Rural Service Centres had been developed as public transport hubs providing shopping, schools, banks, leisure and health services

Throughout the interviews a number of issues resulting from the geography of the District were frequently mentioned and the examples below illustrate the types of problems partnerships had to deal with.

- ***Access to services***

Despite concerted attempts by service providers to improve access, reports from interviewees highlighted the difficulties people in rural parts experienced in accessing services and facilities. Problems involved limited or non-existent transport links from rural service centres to outlying or isolated areas, sometimes exacerbated when people seeking treatment were banned from driving.

“I think that (part of) the issue is just practical stuff, travelling and you know somebody is a dependent drinker and they can't get there in the car or potentially not even on the bus so it's kind of issues like that...” (Team leader, statutory service).

Cost was also an important consideration prohibiting travel, illustrated in the following comment.

“I was recently talking to a couple who brought their son to the X drug and alcohol team and they said well we had to cancel our last meeting because we couldn't afford the petrol to bring him.....And he wouldn't have gone by himself because of the problems he's got.” (Service user representative)

- ***Awareness of services***

The geography of rural areas created difficulties in building awareness of service provision, especially for people living in more isolated communities outside rural service centres. People simply did not know what was available or how to access help. The partnership had responded to these challenges by training professionals – especially GPs – and trying to ensure a consistent response to alcohol-related issues across the District:

“I think one of the main issues is lack of knowledge about the service provision. If they are living outside of the town and their nearest service is kind of in that town then they probably don't necessarily know about it. So I think that that is the main issue - the lack of knowledge and that's why we think it's really important to train the GP; so wherever they go, they should be getting a consistent response to the issue that they're going with.” (Team leader, Statutory service).

- ***Service acceptability***

From comments made by interviewees, it was clear that consideration of service use had to take account also of users' perceptions of the acceptability of the services and of their location. Issues of stigma, a refusal to be associated with illegal drugs and fears of going into 'risky' areas may underpin reluctance to use services. These issues are not unique to rural areas but may be more prominent in areas where there are concerns about visibility.

In one example, police and ward co-ordinators had developed an alcohol arrest referral scheme. The services operated from the city centre with outreach to rural areas. One of the problems identified in take up of the alcohol arrest referral scheme was the lack of local support for young people with alcohol problems. There was a non statutory drug and alcohol agency in a nearby rural town but there was no provision for dealing specifically with young people. The distance and cost of travelling to the town were perceived to be barriers. But more importantly, because of its association with drug misuse and needle exchange, interviewees reported that parents were reluctant to allow their children to attend this local service. Furthermore, because the service was based in an area known to have comparatively high levels of deprivation and crime, this was thought to deter young people from accessing the service.

- ***Staffing in rural areas***

Allied to wider and longer term investment into services were issues concerning staff retention and capacity building, especially in youth services. Rural locations, we were told, were often used as a stepping stone for people to train and gain experience before moving on to the challenges of urban environments; so valuable practical experience obtained in the field was lost. Furthermore, because much work was carried out on a sessional basis, and staff often worked short shifts, the amount of training they could access was limited.

Because of limited staffing and resources, issues of communication and ensuring that strategy was implemented became challenging. For example, providing feedback from the rural WOT (which we visited) to the Alcohol Strategy Group was difficult. As the strategy officer (from the ASG), present at the meeting explained:

*"....I'm conscious that us at the centre we do rely on people working out in the field, to know what issues you are coming up against. I mean we can write strategies and policies and action plans, but if we don't get feedback from people at your sort of level on the ground who know what's going on...
..... Before the youth service was restructured we had somebody from the youth service coming to our meetings. Now it may be that in terms of how the youth service deploys its people it's actually better what it's done (in the restructuring) because at the end of the day, as has become very clear from everything which X (a local person) has said, it's all about delivering the service on the ground and that's where your resources need to be..."* (Strategy officer)

The strategy officer explained how, in one meeting he had attended, the importance and challenges of actual face to face communication and personal contact between the

two agencies working at District and local level became apparent. Discussions had explored young people's needs and the challenges in partnership working and subsequently the strategy officer made arrangements to bring together the Young People's Commissioner with youth services to discuss potential project work.

Rural areas also suffered from lack of access to the wider range of skills mix available in urban localities. A representative from youth services spoke of the broader range of funding streams available in urban and metropolitan locations which allowed for a variety of workers with a greater range of skills in to develop innovative projects and practice. The lack of similar infrastructures in smaller rural settlements was thought to restrict the approaches and projects that could be deployed to tackle (in this instance) young people's issues. The kinds of skills needed could involve anger management, sexual health and relationship issues as well as alcohol and drug issues. This meant that attempts to approach complex problems associated with alcohol misuse through multi-component or interagency collaboration became more challenging.

7.4.3. Prevention and awareness: young people's drinking

Other research carried out in rural areas (Valentine *et al.*, 2007) has indicated that patterns of drinking in rural and urban areas differ among young people and that attitudes towards young people's drinking can also vary across generations. For instance, in our research there were reports of under age young people obtaining alcohol most likely with their parent's consent. However, as Valentine has pointed out, this often occurs in the knowledge that there are limited opportunities and locations for socialising among young people in the countryside.

“And then you've got the maybe the young people who are knocking around, who maybe haven't got an awful lot to do, alcohol may be one of the main opportunities for socialising with young people and also I think because there aren't so many opportunities, maybe parents see it as a fairly legitimate way of passing time.” (Alcohol commissioner)

For young people in the older teenage range, closures of pubs across the District - where drinking behaviours were traditionally learned, meant that opportunities for social drinking had become even more restricted.

In focussing on urban youth drinking, Valentine *et al.*, (2008) argue that the moral panic that has accompanied reports of binge drinking has been transferred to young people's drinking irrespective of location, thereby limiting our understanding of how rural communities think and respond to young people's drinking. This is likely to vary across localities in rural areas and may depend on factors such as the extent of commuting and exposure to urban drinking cultures, isolation of settlements, tourism etc which can affect attitudes and behaviours within local communities. Certainly no major issues of the types of public disorder that can accompany drinking in more urban areas were reported by any of the respondents and disorder in general seemed to be at a relatively low level. However, there were concerns about youth drinking and examples were given of efforts to address the issues.

While isolation and lack of good transport facilities presents problems, it can also offer opportunities for action to address local problems. One example (Box 1) illustrates how the isolated nature of the community can be turned to advantage.

Box 1

Example of good practice in a rural area – tackling under age drinking

A community action project delivered through a partnership led by trading standards was designed to reduce alcohol related problems in young people. The project took place in a small fairly isolated market town and was focussed on reducing under age sales. Part of the project involved encouraging shops and pubs to sign a pledge not to sell alcohol to under age young people as well as getting parents and the local school on board. Significant reductions were achieved. A number of factors specific to rural location were important to the success of the action. In most small rural settlements young people are well known to shop keepers, making underage purchasing more difficult. In communities which are relatively isolated and have poor transport links, purchasing of alcohol would be restricted within the locality, thus limiting the possibilities for under-age purchasing.

Examples of other rural initiatives for young people illustrated the importance of ensuring a range of leisure facilities and other amenities in rural locations (mentioned above as a general problem) – as ‘diversionary’ approaches.

In response to local concerns about under-age drinking and alcohol related anti-social behaviour among young people, the local Ward Officer Team in partnership with Youth Services had developed a pilot youth project in a rural settlement. Young people were invited to attend a youth centre with sports, music, IT activities etc, aimed at delaying alcohol/drug use. This was a novel approach involving partners with different agendas working together with young people, the Ward Officer Team with a criminal justice focus and Youth Services from a developmental and enabling perspective. WOT members reported that the Project had been successful in attracting young people and that levels of anti-social behaviour were in decline.

“They don’t want to have to go in and learn about confidence or feelings you know..

But then it’s the positive relationships that they then build with that PSO (Police Community Safety Officer) which is really important because they are seen as an enforcement, but if they can build that relationship up.

And it’s had a big impact. ...

(It provides).. a positive role model because the PCSO’s are quite young themselves you know some of them so.....They have learned a lot on interaction, how to interact with young people as well, it’s been a two way thing. It’s been very, very beneficial” (Ward Officer Team members)

7.4.4 Working with limited resources

As already noted, developing alcohol services to tackle rural needs presented many challenges. However, in addition to initiatives targeted at young people (illustrated above), there were numerous examples where innovative approaches had evolved at the local level.

The development of a shared care treatment model had proved useful in one deprived urban area set in a more affluent rural hinterland. Collaboration between the District PCT, the voluntary services agency and a service user representative forum had

- reduced duplication of effort (e.g. duplication in assessing clients),
- helped to roll out implementation of IBA (identification and brief advice regarding drinking), in one instance, by providing training within the dental practice of a rural town and also through working in partnership with a wide range of agencies - housing organisations, women's aid and domestic violence groups etc.

The voluntary services agency tried to identify gaps in need either through a needs assessment or research and felt it important that they could explore and pilot new schemes to see if they worked. We were told that:

“....generally how we work at X is that we will identify a need of something and run a little pilot, run probably from reserves or pinching a bit from each pot and then kind of after a three month pilot then we would go to the commission and say we think this is a really important service that you should tender out.” (Voluntary service manager)

Unfortunately, it was often impossible to provide the financial resources needed to offer a more comprehensive service because *“ areas like X (small rural service centre) are very, they have nothing in them very much; it's a rural area and so there is no service provision there”*.(Voluntary service manager)

This approach to service development through experimenting and piloting new ideas was similarly evident in the work of the service user representatives' forum. A representative from the group gave an account of an idea to address issues of home detoxification in rural communities

Professional advice is that community detoxification treatment needs a family member to be living in. This was not feasible for people living alone in isolated areas, particularly if they were highly alcohol dependent. They are not always able to travel to the service for practical reasons, for example because of poor transport links. The service user group suggested responding to these challenges by setting up a 'buddy system' where a member could go and stay with a client in treatment. However, it was reported, they had met with little encouragement from professionals.

“I mean we want to try and set up a buddy type system where perhaps we can go and stay with somebody for a couple of weeks just while they're having this, and we're pushing it but we're not getting very far yet.....Professionals are resisting it.

Why?

Because they don't, because they're saying, well, you're committing and are you ready for this? And I say well look, at the moment you're just saying no, well can we not try it?.....again it's we were just suggesting an alternative, and yes you're going to have to be very much well on board with your own way to recovery, to take this role on, but at least we're saying well consider it, don't just chuck it out.”
(Service user representative)

The service user forum was also trying to set up a scheme in which people who were missing appointments for treatment services could be accompanied, again often for practical reasons, such as taking them on the bus, supporting them in a new environment or during long waiting periods which could be stressful, understanding

and remembering the details of the consultation etc. Although the attempt to establish a 'buddy system' seemed to flag up some tensions between the partners, in general, the efforts of service workers and the users' group to work together in rural areas were recognised as extremely valuable.

"I think our alcohol work in general works very well. We have workers who are really skilled and engaging with alcohol users and I think the brief intervention service is something that has kind of taken off massively and there have been really successful outcomes from that. But then the kind of stuff that doesn't cost us anything; that peer support group that kind of came from the service users. We have 15 people attending that every week and the kind of drive from the service users to have groups over the weekend and stuff like that. So those things that I guess we wouldn't necessarily have thought of doing ... is kind of quite exciting I think." (Voluntary service manager)

"I mean to be honest I think in X, although we don't have a huge amount of resources, financial resources, I think we do an awful lot of service provision; and particularly the voluntary sector; they are very innovative and they do an awful lot above and beyond really; and the services do work very effectively together so yeah.....Yeah they haven't got the money, we've lots of commitment." (Alcohol commissioner)

7.5 Conclusion

Although our case study area was not exclusively rural, the mix of urban and rural was useful in revealing some of the difficulties partnerships face in juggling priorities and resources in mixed urban/ rural areas within which the rural locations included both affluent and deprived communities. The case study found, as expected from research in other fields, that issues of isolation, poor transport links, poor amenities and leisure facilities and less comprehensive service provision impacted on both the delivery of alcohol prevention and treatment services and the ability and willingness of people to access services. The scarcity of funds, appropriate skill mixes, and general resources to respond effectively to prevention, early intervention and treatment needs in rural areas, required collaborative working and innovative approaches. The emergence of local partnerships to address rural issues was one way of addressing the challenges. On the other hand, within already complex partnership structures, the proliferation of smaller partnerships risks increasing problems of communication and over-burdening members of the partnerships. As we have noted elsewhere in this report, the size and inter-connectedness of partnership networks can create difficulties. Nevertheless, in rural areas in particular, forging links across partnerships may be the only way to respond effectively to alcohol problems. This was the view of one commissioner who felt that the way forward was to ensure a place for alcohol on the agendas of partnerships dealing with related issues. For example, in an area where young people's drinking and other risk taking behaviours were perceived as significant concerns:

"....It's sort of finding out what other rural issues there are and bringing that into the mix because obviously alcohol and sexual health are very tied up together and we may be looking at forging opportunities to introduce alcohol into those kind of agendas with other partners and maybe making new partnerships, like getting involved in sexual health partnerships, forging new channels really..... I think it would be a waste of money just setting up a

discreet service because especially with young people, alcohol is just one thing; they kind of deal with lots of other things. It's that growing up isn't it? They need advice about all sorts of things and they all interact with each other. We know that young people are less likely to use condoms and think about contraception if they've been drinking so it's kind of getting those messages across." (Alcohol commissioner)

8. Perceptions of Outcomes and the Future

This study did not set out to measure the extent to which partnerships were successful in achieving their aims or delivering their targets. We were interested in how those involved in partnership working judged the success of their partnerships and what they considered to be their achievements over the previous twelve months.

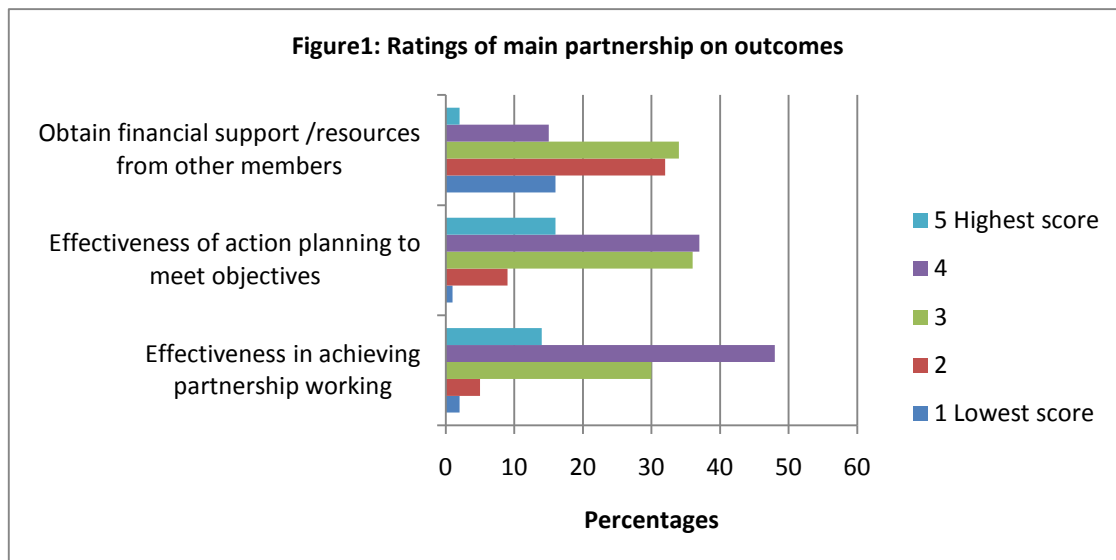
8.1 Partnership working as an achievement

Survey respondents were asked to rate three outcomes: effectiveness in achieving partnership working; effectiveness in action planning to meet objectives; and effectiveness in obtaining financial support/resources from member agencies. The mean scores in table 1 below again show that respondents were less satisfied with outcomes than with the structural aspects of their partnership which were reported in chapter 4. While effectiveness of working as a partnership and planning actions to meet objectives were rated comparatively highly, not surprisingly obtaining financial support and resources from member agencies appeared to be most challenging. This can be seen more clearly in figure 1 where the lowest scores of 2 and 1 are given by comparatively high proportions of respondents.

Table 1: Mean scores for rating main partnership on outcomes

Dimensions:	Means
Effectiveness in achieving partnership working	3.67
Effectiveness of action planning to meet objectives	3.58
Obtain financial support/resources from member agencies	2.55

5=Highest score 1=Lowest score



Despite financial and resource constraints, and the many challenges faced in making partnerships work – reported in earlier sections – most interviewees were positive about their partnerships and were able to report key achievements over the previous year.

8.2 Key achievements in the previous 12 months

Asked to indicate the main achievements of their partnership within the last 12 months, respondents provided a very wide range of responses. All partnerships noted at least one main achievement; the majority fell under either health or criminal justice agendas.

- Crime reduction was the main achievement for many (28%):
“A and E Assault data pilot in one acute trust due to go live……. Many borough CDRPs ran local campaign during alcohol awareness week.” (30)
- Alcohol service related achievements were important, for example developing or expanding alcohol care pathways and services (18%), providing brief interventions (7%) and getting more people generally into treatment (5%):
“We’ve made progress in looking at improving alcohol treatment in terms of the vision of how it needs to be developed and improved, so in terms of the commissioning perspective, the vision and objectives for alcohol treatment, which no-one had really looked at before.” (58)
- Having clear strategic direction in developing the alcohol agenda (11%) and developing the alcohol strategy (16%) were also important achievements:
“Alcohol has been fully embedded in to joint commissioning groups, historically these only focussed on drugs.” (30)
- Getting alcohol firmly established on agendas was hailed as an achievement:
“In the last 12 months we’ve achieved putting alcohol agenda at a very high strategic level and off the back burner. We have strong leadership, not just champions, but people who are quite pro-active and engaging with the alcohol side” (32).

Table 2 shows the main achievements mentioned. Other achievements were also given by small numbers of people (4%-5%).

Table 2: Key achievements in last 12 months

Key achievements:	%
Reduction in crime/alcohol related crime/violent crime/offending	28
Development/expansion of alcohol services / care pathways	18
Development of alcohol harm reduction strategy (alcohol plan)	16
Implementing projects/campaigns	16
Clearer strategic direction to develop alcohol agenda / alcohol has become prioritised	11
Securing funding/investment (specified and unspecified reasons)	11
Establishing better links with other services e.g. gastro-enterology, sexual health, young people’s services, PCTs, community safety, education etc	11
Developing brief interventions	7
Meeting targets	7
Re-commissioning/reviewing alcohol (and drug) treatment services	7
Holding specific events e.g. conference, workshop etc	5
Increasing number of individuals in alcohol (and drug) treatment	5

Based on number answering: 83

8.3 Looking to the future

Respondents were invited to suggest what would be of most help to them in achieving the aims of the partnership over the next 12 months. As can be seen in Table 3 below, and of little surprise, increased or ring-fenced funding was considered to be most beneficial (63%).

“Sustainable funding / resources, not funny money and ideally it would need to be ring-fenced as to its intention based on the outcomes to achieve. National drive to ensure that alcohol is a priority within all public services, not just health and local authority.” (09)

Preserving the relationships and commitment they had worked hard to establish was also notable (19%) as was having strategic direction and clear action planning (18%).

“Clarity of purpose and determination by the DAAT officers, Chair and a couple of key board members to keep the partnership going and to stand up for X (the area) and keep our course, ultimately being vindicated through our targeted performance.” (16)

“The development of integrated performance management systems (i.e. LA, police and health) will enable us to be much clearer regarding positive / negative outcomes from joint-commissioning. We also need to identify some other useful outcome measures outside of those of National Indicators to chart our ‘signs of success’.” (26)

A further important consideration was making alcohol a priority at national level and ensuring good information sharing as, it was believed, this would be aligned to, and facilitate, partnership aims (9%).

“Central funding allocations for alcohol – it is a far bigger issue for X (the county) than drugs but attracts very little central money outside of the NHS choosing health funding. Partners have been very supportive to not let this prevent work progressing but the scale of the issue locally and nationally needs more than guidance that is emerging from the centre.” (49)

“Better information from government departments (mainly Home Office, DoH and DCSF), regarding developments and communication plans so that locally we can tie in our messages and getting the information in a timely manner so action can be taken.” (23)

Table 3: Most helpful to partnership to achieve aims in next 12 months

Most useful:	%
Increased funding / resources / ring-fenced funding for alcohol	63
Good working relationships/ commitment / communication/continuity of membership	19
Strategic direction/clear action planning/performance managing	18
Ensure alcohol is a priority nationally / in public services	9
Nothing	1

Based on number answering: 68

8.4 Conclusion

Respondents accounts indicated that, despite the many problems and challenges documented in earlier chapters, they felt positive about outcomes in terms of partnership collaboration and with respect to achieving targets for prevention approaches and service provision. However, in looking to the future, there are indications that some people, at least, were concerned about continuing low levels of financial support and were uncertain that partnership working could be sustained and improved over the longer term.

9. Conclusions

Collaborative and inter-agency working – whatever the label applied to it – is not new. But the concept of ‘partnership’ has a younger pedigree and has emerged since the late 1990s as a dominant model for the delivery of policy to address ‘wicked’ issues, those complex health and social problems requiring complex solutions. ‘Partnerships’ have become the key mechanism for the delivery of national policy at local levels in many areas of health, criminal justice and social welfare. The emergence and development of partnerships in the alcohol field is, therefore, part of a much broader shift towards establishing a strategic framework for inter-agency and inter-professional collaboration at local level as opposed to the more ‘organic’ forms of joint working characteristic of earlier periods. In this study, we focussed on aspects of professional collaboration; we did not ask about ‘community’ involvement and, interestingly, it was rarely mentioned even in accounts of partnership membership.

The move to alcohol partnerships was clearly evident from our data which found a range of partnership types, variably structured and formalised, often ‘nested’ within larger partnerships or organisational structures and operating as part of a partnership network. Evidence of the push towards establishing a strong collaborative infrastructure for policy implementation was found in the growth of partnership co-ordinator posts (under a variety of titles) and in the formation of new partnerships within a comparatively short period following the publication of *Safe. Sensible. Social.*, in 2008 (DH, 2008). There was recognition that ‘buy in’ from the top and an alcohol ‘champion’ to raise the policy profile of alcohol were necessary ingredients for the success of partnerships; this was instrumental in creating a number of ‘appointed champions’ at local level as part of a more formalised and regulated system of collaborative working.

Accounts of partnership working were largely positive and the necessity of working collaboratively across professional boundaries was rarely challenged. On the contrary, there were frequent comments regarding the problem of overcoming a ‘silo’ mentality arising both from professional and occupational cultures and from institutional embedding which gave rise to tensions around accountability, responsibility and priority setting. At least in part, ‘silo’ working was seen as coming from the top down; while local agencies were being persuaded to form partnerships which crossed boundaries, collaboration between government departments was seen to be constrained by competing priorities, pressures from different interest groups and ring fenced funding. This generated conflicting demands on partnerships which were required to respond to local needs and, at the same time, comply with departmental boundaries and restrictions, for example, on setting priorities and sharing resources.

Despite positive rating of partnerships, respondents spoke at length about the considerable challenges faced by individuals working within increasingly large, complex partnership structures. Key issues raised were:

- Funding and resources: This included the need to manage cuts in resources, often in the face of increasing demands and existing tensions around prioritising aims and targeting resources.
- Establishing shared priorities and goals: This proved a major challenge in many cases and, although resource issues were important, there were other factors which impeded the development of shared goals; establishing trust

between partners was mentioned frequently as a major barrier or facilitator; good communication and information sharing was seen as vital to successful partnership working but difficult to achieve; institutional ‘embedding’ sometimes made it difficult for partners to reach an agreement on priorities and resource allocation. The problems were exacerbated in areas where partners were working across non-coterminous boundaries with different layers of authority and multiple partnership structures and where ‘politics’ was more likely to come into the picture.

- **Gaining and maintaining commitment:** It was stressed that involving ‘top people’ and the ‘right’ people at the ‘right’ level was fundamental to ensuring that alcohol issues were part of local agendas, that there was continuing awareness of alcohol as a factor in many other health, social and criminal harms and that resources were directed towards addressing alcohol-related harm. The appointment of alcohol ‘champions’ was seen as one way of raising the profile of alcohol in local areas.
- **Tackling professional cultures and ‘silo’ approaches:** Changing professional behaviour was recognised as a major problem in partnership working. Individuals, through their professional training and their positions within occupational cultures and institutional settings developed values and particular ways of seeing the world which were often difficult to challenge or change. Training and building experience of successful collaboration were suggested as a way to combat ‘silos’.
- **Managing size and complexity:** As noted above, there has been a proliferation of partnerships within the last decade. Partnership networks are complex, overlapping and ‘nested’ within one another. Some partnerships are part of a highly structured hierarchy with different levels of strategic and implementation partnerships. For respondents, this meant that co-ordination of goals and priorities became increasingly difficult and the time and resources needed for the co-ordination of the different partnership levels were not available. Large partnership groups also ran the risk of being seen to fail to respond to local needs.
- **Responding to rural needs:** The need to respond to local needs was a major concern in areas with a large rural element within a mixed urban/rural context. Attention tended to focus on the majority urban population and the general lack of amenities and services in the rural areas made it more difficult to address alcohol-related problems. The development of local partnerships (itself adding to the complex network of partnerships) and ensuring that alcohol issues were included across different partnerships were ways of managing the unequal urban/rural emphasis.

The challenges to alcohol partnerships are similar to those described in studies in other policy domains and, as mentioned in section three of the report, have resulted in guidelines and tools for developing and monitoring successful partnerships. There is, therefore, a wealth of experience and knowledge to draw on in forming partnerships in the alcohol field. Responses from key interviewees and survey respondents in this study demonstrated a latent – if not overt – recognition of the six principles of partnership working employed in the Partnership Assessment Tool. But the extent to which alcohol partnerships have started out with, or arrived at, a clear vision of collaborative working and understanding of the principles which could guide development is doubtful. It may be that learning from other policy domains has not

reached those involved in forming alcohol partnerships. Certainly, in the alcohol field as elsewhere, the same problems and barriers to partnership working crop up each time. On the other hand, respondents in this study were aware of the factors which influence collaborative working and showed a sense of frustration that some of the problems arise from sources beyond the power of local partnerships. It is possible that the principles of successful partnership working are well known but other reasons stand in the way: failure to take time at the start and apply basic principles of partnership working; lack of willingness among partners to work together, compromise or reach shared objectives, to communicate and share information, or to resolve competition for resources; or, as we have seen in this study, problems of managing large complex systems of collaboration. There is, therefore, a need to examine in more detail the assumptions and hypotheses underpinning partnership approaches and the practicalities of implementing the principles of partnership working.

Partnership working is based on a consensus model which, as has been found elsewhere, is difficult to achieve particularly in a policy context which demands cultural and organisational change among its partners (Sullivan and Stewart 2006). Initiating and managing change to address alcohol-related harm is a core function of partnerships; but to achieve the desired outcomes in terms of providing better services, reducing harms or lowering the rate of problem consumption, partners have first to accommodate one another and find ways of establishing structures and procedures to achieve mutual goals (as detailed in the partnership assessment tool). This takes time and, in a swiftly changing policy context and changing structural frameworks, large, formal partnerships and partnership networks may find it difficult to respond quickly and flexibly enough to new circumstances. It may be that these issues are more relevant to understanding 'formal' partnerships which are created with the specific purpose of delivering policy (e.g. Community Safety Partnerships) than partnerships which evolve organically from perceptions of local need (as in rural areas described in section seven).

Partnership structures and interaction in the alcohol field are still evolving and changing – and this is likely to be a permanent feature for the foreseeable future as health, social welfare and criminal justice structures continue to change. As mentioned earlier, partnership working has clearly become embedded in practice as the accepted model for the delivery of alcohol policy and is likely to survive the changes. However, given the shift towards more formal, regulated and, perhaps, compulsory partnership working, the formation and maintenance of effective partnerships need closer examination and monitoring. Establishing the primary purpose of collaborative working and ensuring that it does not encroach on, or overlap with, the core 'business' of other agencies and partnerships may go some way towards countering the trend towards larger, more complex partnership structures and the time and resources they absorb. But, looking to the future, we need to ask if the expectations of what partnership approaches can deliver are too high. There is a case to be made for questioning the taken-for-granted acceptance of partnership working and for suggesting greater scrutiny of the function of the partnership and the added value it brings.

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