The reality of partnership working when undertaking an evaluation of a national Well Men's Service

Garth D. Reid, Edwin R. van Teijlingen, Flora Douglas, Lynn Robertson and Anne Ludbrook

Keywords

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Garth D. Reid, BSc, MSc
Department of Public Health, University of Aberdeen, UK

Edwin R. van Teijlingen, MA, Med, PhD
Department of Public Health, University of Aberdeen, UK

Flora Douglas, BN RGN, PgDip, MPH
Department of Public Health, University of Aberdeen, UK

Lynn Robertson, BSc
Department of Public Health, University of Aberdeen, UK

Anne Ludbrook, BA, MSc
Health Economics Research Unit, Polwarth Building, University of Aberdeen, UK

E-mail:
g.reid@abdn.ac.uk

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Abstract

Background: Partnership working has been a key tenet of health policy in Scotland since 1997. Much has been written about the benefits of partnership working, but it has been difficult to prove its effectiveness. This paper describes the reality of working in partnership when undertaking an evaluation of a complex intervention aimed at engaging with hard-to-reach men to improve their health.

Methods: A collaborative model of working was used to develop an evaluation tool to assess the effectiveness of the intervention. Six phases were used in the developmental process each involving a different group of stakeholders. The progress through these phases was not linear; it involved numerous iterative feedback loops. A number of challenges were faced at each phase and steps were taken to overcome them.

Results: Four lessons emerged which are more generally applicable. Collaborative working is a slow process, a fact which key advocates in the field have failed to recognise. Study participants need to be included in partnership working, particularly men. Partnership working can be arduous and those undertaking it should be prepared for the difficulties ahead since the key to success is being able to overcome these challenges. Flexibility is a key element to the successful evaluation of community-based large scale interventions.

Conclusion: This research identified that it is important to be flexible to meeting the changing needs of stakeholders involved in the evaluative process.

Introduction

In 1997 the new Labour government in the UK identified that the way industrial relations were carried out between the country's public institutions needed to be radically overhauled [1]. As a result, partnership working became enshrined as a cornerstone of governmental policy for the NHS in the document '*Towards a New Way of Working – The Plan for Managing People in the NHS in Scotland*' [2]. This development was not in isolation, in the same year the WHO released recommendations for policy makers extolling the virtues of participatory working. They stated that '*. . .participatory approaches to evaluation help foster the process of empowerment and build stake-holders' capacity to address health needs*' [3]. Partnership working continues to be part of governmental policy and has been held to be effective [4]. A wide range of terms is now used to describe partnership working in its broadest sense, i.e. that of individuals or organisations working together. Terms such as joint working, participatory working, collaboration, coordination, interagency working and more are commonplace [5].

Research has indicated that collaborative working has some benefits. It can improve the skills of the members of the partnership and increase the efficiency of the work that is

undertaken [6,7]. It also has wider indirect benefits to the individuals and institutions involved, such as increasing the strength of relationships, the sense of ownership and even producing synergy which would not otherwise have been created [7,8]. Partnership can also be essential to improving practice and implementing new guidelines and ways of working [9].

Despite its political importance and perceived benefits, researchers have struggled to prove that participatory working is effective for a variety of reasons [10]. It is difficult to measure and there is little evidence that it achieves better outcomes than other methods of working [5,11]. Other challenges include, difficulties reaching agreements between groups, maintaining involvement of all stakeholders, sustaining a sense of ownership and assessing the cost and effectiveness of the partnership [12,13]. It can also be a very slow process [14]. Some argue that modern ways of working act as substantial barriers to effective collaborative working. Professional boundary guarding, a lack of collective goals and different accountability structures have all been linked with ineffective partnership working [15].

The fields of participatory working and evaluation have become closely linked [16]. It has been used in evaluation in a range of different ways, for example to develop evaluation methods which are appropriate to the stakeholders [17]. In addition, individuals have been involved in the evaluation process as part of a representative group of stakeholders [18]. Partnership working has also been used to make evaluation useful for its intended users [19]. As a result it has added an extra level of complexity to evaluation at a time when there is increased expectations of what evaluation can and should achieve. Evaluations are expected to be flexible; theoretically based; able to elicit programme theory and uncover the mechanisms by which an intervention works [20,21].

This paper seeks to describe the reality of working in partnership with multiple stakeholders in developing an evaluation tool for a complex, community-based intervention aimed at improving men's health or encouraging men to access health and social care services. It highlights some of the challenges faced, which are common to much of partnership working, and how they were addressed.

The intervention

In 2003 the Scottish Executive (now Scottish Government) commissioned a complex, community-based intervention entitled the Well Men's Services (WMS) pilots [22]. Partners from the health, local authority, voluntary and private sectors were invited to create innovative pilot projects aimed at engaging with a range of hard-to-reach men. Hard-to-reach men were defined as being *'. . .socially excluded (by either their age, faith/religious beliefs, sexuality, disability, or race/ethnicity) or because of a general lack of interest or concern. . .'* [22]. Part of the evaluation brief provided by the Scottish Executive was to develop a tool to collect consistent monitoring and evaluation data from each of the WMS pilots. The evaluation team relied upon the staff of the WMS pilots to collect this data.

The WMS pilots consisted of 18 individual projects across seven health regions in Scotland. Each project had unique characteristics and was developed locally in response to the call from the Scottish Executive [22]. Interviews held with staff revealed they held a range of different philosophical perspectives on men's health, which impacted on the type of intervention they implemented. Some carried out interventions based on a so-called *'medical model'*, whereas others used a *'social model'* approach [23]. The medical model represents the medicalisation of healthcare, focusing on clinical diagnosis and the aetiology of disease [24,25]. In contrast the social model takes a holistic view of healthcare, focusing on the prevention of ill health [26]. The evaluation team asked each project to classify their work according to: the intervention they carried out, the setting used and the group they targeted.

Intervention type was classified as fixed, outreach and mobile services. Fixed services were categorised as any intervention, which included services provided in a mainstream health setting. Outreach services refer to interventions undertaken in locations where men met for work and/or leisure (e.g. sports ground, shopping centre and workplace) that do not have a health focus. Mobile services were services offered peripatetically in the community on a temporary basis (e.g. mobile bus). Some WMS pilots carried out activities that included more than one category.

The categories for the setting where the intervention was taking place were classed