

Lawrence Benson and Gillian Wright

Lawrence Benson

Lecturer in Healthcare and Public Sector Management

Manchester Centre for Healthcare Management

Manchester Business School, University of Manchester

Devonshire House, University Precinct Centre, Oxford Road

Manchester, M13 9PL, UK

Tel: +44 0161 275 2918

Email: Lawrence.benson@man.ac.uk

Gillian Wright

Chair of Strategic Marketing

Director of Research

Manchester Metropolitan University Business School

Aytoun Building

Manchester

M1 3GH

Email: G.Wright@mmu.ac.uk

Biographical notes:

Dr Lawrence Benson

Dr Lawrence Benson is Lecturer in Healthcare and Public Sector Management at the Manchester Centre for Healthcare Management, Manchester Business School, University of Manchester. His research is concerned with partnership and strategic alliances, workforce redesign and regulation within health and social care. His professional background is as a health service manager in the NHS.

Professor Gillian Wright

Professor Gillian Wright is Chair of Strategic Marketing and Director of Research of the Research Institute for Business and Management at Manchester Metropolitan University. Her research is concerned with service quality, effective strategic change and knowledge management in the public services. This focus builds on ten years research experience in service delivery in healthcare. She is a visiting Fellow at the Nuffield Institute for Health at the University of Leeds. Her professional background is as a Market Analyst in electronics and Market Research in pharmaceuticals.

EFFECTIVE PARTNERSHIP WORKING IN HEALTHCARE

Key Words

National Health Service, primary care groups, team effectiveness, strategic alliances, hybrid organisational forms, multiple regression.

Abstract

This article is intended to establish the perceived effectiveness of hybrid organisational forms (HOFs) in the English National Health Service (NHS) i.e. Primary Care Groups. This is done through the analysis of data from the early experiences of board members of these new forms. The study consists of a literature review of strategic alliances and partnership between organizations and then a methodology based upon an exploratory series of qualitative interviews and a survey of over 300 participants in professional executive committees and boards many of whom had not been previously involved in the governance of large healthcare organizations. The survey is based upon an adapted conceptual model of senior teams working in new HOFs. The data analysis includes content analysis, factor analysis and multiple regression. The validity of the conceptual model is tested and a scale for effectiveness for the HOFs is developed. Effective leadership, managing powerful professional groups, and quickly achieving small successes are highlighted as particularly important in further strengthening these partnerships. The paper is presented at a time when the English NHS is entering another period of structural reform particularly in primary care.

INTRODUCTION AND CONTEXT

This study explores the construct of partnership within the executive boards of NHS English Primary Care Groups (PCGs) in the period 1998 to 2002 (Benson, 2003). Partnership and collaboration had been used by government from 1997 onwards as expected ways of working between public bodies and, more particularly in the context of this study, between health and social care organisations.

There were numerous reasons in 1998 why PCGs were attractive as a research focus. These included their apparent (but disputed) newness of approach (Maynard 1998), their national scale, their intended wide ranging roles for the organisation of health care and services, their formal attempt at institutionalising collaboration and partnership, their wide board membership, and their period of birth and transition from 1998 to 2002.

The study examines the PCG as a potential mechanism of partnership within the context of the literature of collaborative alliances and specifically focuses on the micro environment of the PCG board.

Health Policy and Reform

The UK health care reforms of the 1997 Labour administration (DOH, 1997; Scottish Office and DOH, 1997; Welsh Office, 1997) formally rejected the 'internal market' as a model for organisation of the NHS. The effectiveness of the 'internal market' had been widely discussed and disputed by politicians, academics, and health professionals (Labour Party, 1995; Le Grand *et al.*, 1998; Webster, 1998). The emphasis was now to be on partnership between health organisations and, indeed, between the NHS and other agencies / communities who had an input to improving

health in a locality (DOH, 1997; DOH, 1998 a). The formal rejection of competition, to one of partnership, then led to practitioners searching for different theoretical frameworks to help understand the new demands of this approach.

PCGs

The UK's National Health Service (NHS) entered a period of major reorganisation in 1997 and perhaps this was no more radically felt than within the primary care sector. The purpose and roles of PCGs were specified as:-

GPs in an area together with community nurses will take responsibility for commissioning services for the local community. They will work closely with social services. There will be four options for the form that PCGs can take ... including the opportunity to become freestanding Primary Care Trusts (PCTs), with responsibility for running community hospitals and community health services.
(DOH, 1997)

There were four levels of PCG envisaged (DOH, 1997) detailed in table 1.

Table 1
The Evolution of Primary Care Organisations (PCOs)

Level	Status	Role	Type
Level 1 from April 1999	Advisory sub committee to the local health authority	Advice on commissioning health services for resident population	PCG
Level 2 from April 1999	Sub committee to the local health authority with devolved responsibility	Commissioning some health services for resident population	PCG
Level 3 from April 2000	Freestanding public body - nationally accountable to the Secretary of State, locally accountable to the local health authority	Commissioning some health services for resident population	PCGs and PCTs
Level 4 from April 2000	Freestanding public body - nationally accountable to the Secretary of State, locally accountable to the local health authority	Commissioning health services and providing some community health services for resident population	PCGs and PCTs

Source: Adapted from DOH (1998b)

Membership of PCG boards

PCG boards at levels 1 and 2 were multi-professional, GP dominated, tied with existing organisational structures (sub-committees of the Health Authority), and had new categories of membership outside health, such as social services and lay representation. The Health Act (1999) allowed for PCGs to pursue the more radical levels of 3 and 4 which gave Primary Care Trust (PCT) status. There were 17 PCTs initially established in England from April 2000 and by April 2002 all PCGs had been replaced by PCTs (PCG levels 3 and 4). The study was concerned with whether the

PCG board was an effective mechanism for partnership working addressing this focus through the development of four research questions:

- 1 What inputs in the creation of a PCG board are important in effective partnership?
- 2 How can processes hinder or promote partnership working of a PCG board?
- 3 What are the team working outcomes of PCGs?
- 4 What initial outputs have resulted from PCG boards which have influenced further partnership working?

The remainder of this paper contains a review of the literatures that influenced the study, principally those of organisation design, strategic alliances, partnership and team effectiveness. Then an outline of the methodology adopted for the study is given which included a series of qualitative interviews followed by a survey. A presentation of the main findings from the study is made and discussion from these is given.

LITERATURE REVIEW

The literatures of hybrid organisational design, strategic alliances, partnership, and team effectiveness all influenced the study.

Organisational Design

Borys and Jemison (1989), within a discussion of multi-national strategic alliances, defined hybrids as

organisational arrangements that use resources and / or governance structures from more than one existing organization ... A hybrid is simultaneously a single organizational and a product of sovereign organizations. This conjunctive nature of hybrids and the possibility for multiple levels of analyses call for an open systems approach ... which allows the researcher to simultaneously address relations amongst and within organizations. (p. 234 - 235)

PCGs represent organisational hybrids - the members of these teams were drawn from different organisations (from both health and social care sectors) with very diverse organisational / professional structures and cultures. These also had different recent experiences of health policy reform in the period 1991 – 1997. The General Practice model of organisation was based primarily on very small and highly autonomous organisations, whilst, PCG team members from NHS Trusts and, Social Service Departments were from cultures of large, often bureaucratic, organisations.

Strategic Alliances

The inter-organisation strategic alliance literature revealed parallels between such alliances and partnerships in public services. A strategic alliance has been defined as:

Relatively enduring interfirm co-operative arrangements involving flows and linkages that utilize resources and / or governance structures from autonomous organisations, for the joint accomplishment of individual goals linked to the corporate mission of each sponsoring firm. (Parkhe, 1991, p.581)

Effective strategic alliances are dependent on a process ‘through which parties who see different aspects of a problem can constructively explore their differences and search for solutions that go beyond their own limited vision of what is possible’ (p.5, Gray and Wood, 1991). During their early phases PCGs were examples of such inter-organizational co-operative arrangements or strategic alliances, GP practices, health authorities, NHS Trusts and social service departments being expected to link and work together to attain shared goals. However, during this early period these organisations remained autonomous. The factors which explain the success of strategic alliances in competitive environments have been identified as:

- Development of a common culture between partner organisations (Segil, 1998) or at least the reconciliation of cultural differences (Harrigan, 1988; Parkhe, 1991; Rule and Keown, 1998);
- Commitment to the alliance with sufficient management time, trust and respect being given (Ring and Van de Ven, 1994; Gulati, 1995; Spekman *et al.*, 1998; Whipple and Frankel, 2000);
- Development of a common understanding as to the relative power the partners will have and share (Spekman *et al.*, 1998);

- Management of any loss of autonomy for partners and the weakening of partners (Hamel *et al.*, 1989);
- Open communication between partners (Reardon and Spekman, 1994);
- Monitoring of customer responses (Segil, 1998);
- Clear strategic consistency (Rule and Keown, 1998) between partners including the management of the collaboration / competition dilemma (Hamel *et al.*, 1989; Lei and Slocum, 1992);
- Flexibility in relationships (Segil, 1998);
- Ability to successfully define roles within the alliance and foster teamwork (Powell, 1990; Mohr and Spekman, 1994);
- Prevention of individual personalities from detrimentally affecting the alliance relationship (Segil, 1998);
- Measuring and reviewing the alliance (Segil, 1998).
- Recognition of the particular leadership challenges posed for senior executives and managers when developing strategic alliances if new interorganisational arrangements are to become effective (Weiner *et al.*, 2000; Judge and Ryman, 2001).
- Political support for the alliance from the respective hierarchies of the partner organisations (Lorange *et al.*, 1992).
- A mutual willingness and ability to learn from each other (Child and Faulkner, 1998).

All of these success factors were considered when conceptualising effective partnership working in PCOs.

Advantages and Problems of Alliances

The advantages of strategic alliances particularly relevant to public service partnerships include the learning of new competencies (Ohmae, 1989; Hamel, 1991), access to additional resources (Parkhe, 1991; Bronder and Pritzl, 1992; Teece, 1992), thus being in a better position to respond to market demands and technological opportunities (Halverson *et al.*, 1997). Alliances also offer the opportunity to act as a precursor to the merger of organisations (Spekman *et al.*, 1998). Equally there are a series of costs or disadvantages which can be associated with alliances, which include the loss of resources, autonomy and control and possible delays linked to co-ordination (Halverson *et al.*, 1997; Whipple and Frankel, 2000). Child and Faulkner (1998) explore general management within strategic alliances noting that like PCOs this is:-

more challenging than that of integrated firms, because it involves maintaining active cooperation between two or more partner companies whose agendas are overlapping rather than identical. (p. 336)

Alliances in Health and Social Care

The US literature is rich with comment and review of strategic alliances in health care and the human services as a way of commissioning or providing services across and within public and private sectors. Strategic alliances have been widely used as a basis to review the commission and provision of care services across and within the public and private sectors in the US (Halverson *et al.*, 1997; Shortell *et al.*, 2000; Weiner *et al.*, 2000). Bailey and Koney (2000) developed a continuum of types of alliance drawing on earlier research on interorganisational relationships, (Oliver, 1990). Their typology is mapped onto UK Primary Care in table 2.

Table 2
Levels of Strategic Alliance in UK PCOs

Strategic alliance level	Examples	PCG Level
Co-operation - sharing information between organisations but each organisation is still fully independent of each other	Affiliations	Pre PCG for GP and Community Services
Co-ordination - otherwise autonomous groups align activities, sponsor particular events or deliver targeted services in pursuit of compatible goals	Federations, associations, coalitions	Level 1
Collaboration - parties work collectively through common strategies. Each relinquishes some degree of autonomy toward the realization of a jointly determined purpose	Consortia, networks and joint ventures	Levels 1 and 2
Coadunation - here the participants agree to work within a new integrated structure and an independence is surrendered to a surviving organisation	Mergers, consolidations, acquisitions	Levels 3 and 4

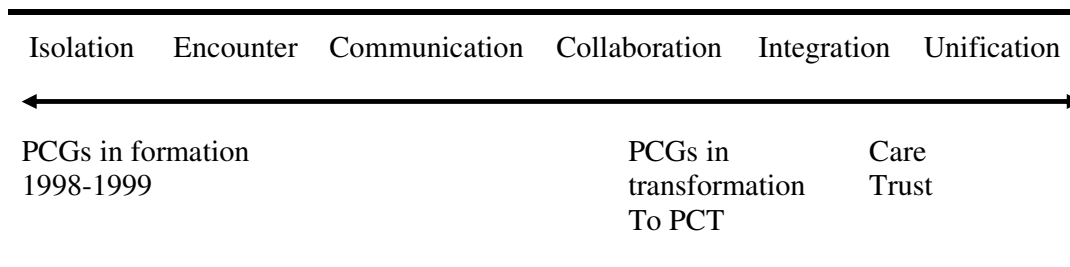
Source: Adapted from Bailey and Koney (2000)

The Challenge of Partnership in Public Services

The ideas of integration, partnership and networking, integral to primary care policy have been analysed and developed throughout the 1990s (Flynn *et al.*, 1996; Ranade, 1997; Hudson, 1999; Jackson and Stainsby, 2000). There is still however confusion in the literature about the conceptual definitions of partnership and collaboration between public service organisations (Ling, 2000; Powell *et al.*, 2001; Glendinning, 2002). Despite these reported difficulties, there have still been attempts to establish evaluation criteria of post 1997 UK public service partnerships (Glenninning, 2002). Hudson *et al.* (1997) identified organisational, operational, professional and cultural problems as constraints on effective partnership and collaboration in the UK healthcare provision. The development of inter-professional and inter-organisational trust has been identified as key in stimulating effective integration of service delivery, together with shared ownership and vision (Powell and Exworthy, 2001). A collaborative continuum has been proposed (Figure 1) with the degree of integration increasing from isolation through to integration (Hudson, *et al.*, 1997), PCOs move through this continuum over the period of this study - from positions of encounter to greater collaboration and, integration.

Figure 1

Framework for collaboration



Source: Hudson *et al.* (1997)

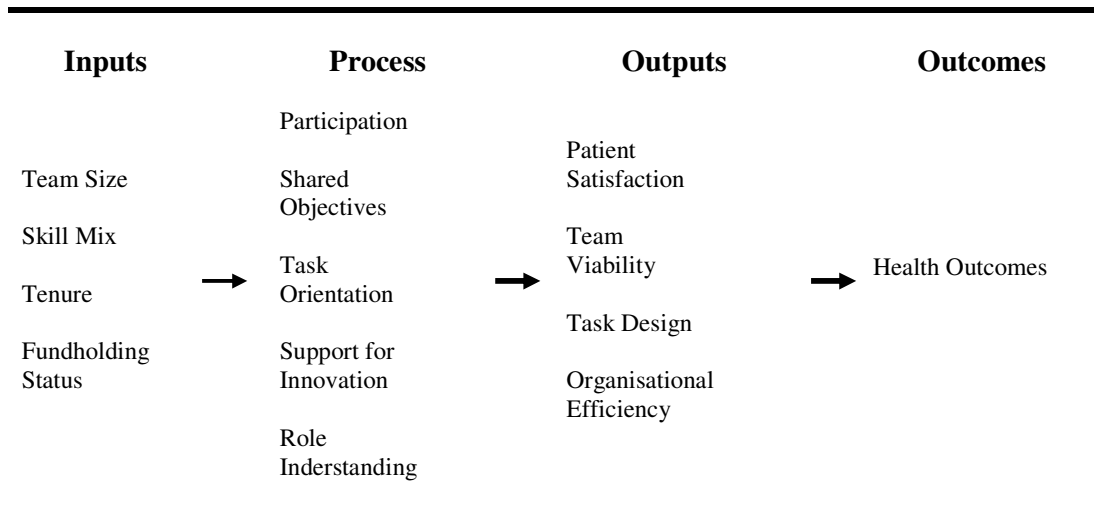
Team Effectiveness in Primary Health Care

This research began in an environment in which there was considerable evidence, from general practice and community staff, of major barriers to effective Primary Health Care Teams (PCHTs). In many areas of the NHS there was considerable evidence at the start of this study of major barriers inhibiting highly effective PHCTs drawn from GP practices and NHS Trusts' community staff (West and Slater, 1996; Øvretveit, 1997; West and Poulton 1997; Gerrish *et al.*, 1998). Indeed, many were labelled as examples of quasi teams, underdeveloped groups and teams in names only. This did not bode well for the development of entire organisational forms, in the same environment, with many of the same people as actors. There was also considerable research to suggest that there was a relative imbalance of power between professional groups working within primary and community care (Hudson, 2002).

Poulton and West (1997) developed an empirical model (see Figure 2) designed to measure the effectiveness of Primary Health Care Teams based on a systems model approach to the effectiveness of teams - inputs, processes, outputs, and finally outcomes from the team (Hackman, 1990). There is a recognition amongst UK researchers that most on effectiveness research has been focussed in the areas of processes and outputs. (Poulton and West, 1997; Pearson and Spencer, 1997), and there is an acknowledged lack of research addressing outcomes.

Figure 2

A Model of Primary Healthcare Team Effectiveness



Source: Poulton and West (1997)

METHOD

A survey of PCO managers (n=336) followed a programme of semi-structured interviews (n=13) based on a conceptual framework of team effectiveness and strategic alliance success factors. The face, content and construct validity (Bowling, 1997, Bryman, 2001) of the second phase of the study was strengthened by the outcomes of the interviews. The interview schedule was designed with reference to an established model of team effectiveness (Poulton and West, 1997) and a typology of partnership (Pratt *et al.*, 1998).

The interviews were reviewed by using a framework for qualitative interviewing developed by Kvale (1996). The sampling frame was a census of one region, of eight in the UK, thus increasing the argument for the external validity of this phase of the study.

The administration of the questionnaire followed an adapted protocol (Dillman, 1978) for increasing a response rate, and an encouraging and adequate overall response rate of 43.6% was achieved. This response of 336 board members represented approximately 5.5% of the UK population of 6200 members. The sample profile is summarized in table 3.

Table 3
Sample Profile

Role	Number (%)	
GPs	105	(31.3)
Nurses	72	(21.4)
Social Services	35	(10.4)
CEOs	29	(8.6)
Other	28	(8.3)
Lay Members	24	(7.1)
Chairs	22	(6.5)
Health Authorities	21	(6.3)
Total	336	(100)

Survey Instrument

The individual survey items were mapped against the constructs of partnership working, its dimensions and sub-dimensions using a conceptual model to underpin the face, content and construct validity of the questionnaire. This derivation of multi-item variables is summarized in figure 3.

Figure 3
The Ladder of Abstraction: from Concept to Operationalisation

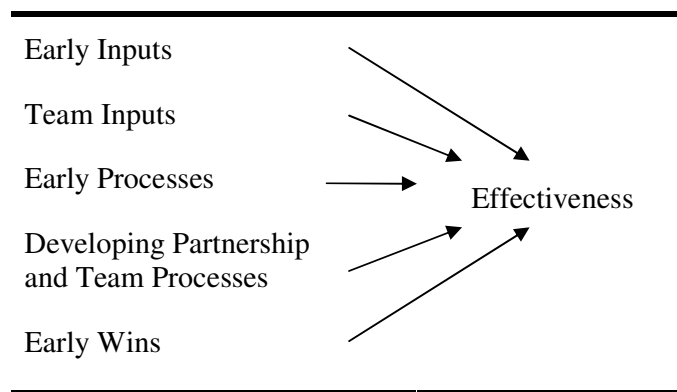
Concept	Dimensions	Sub-dimensions	Indicators: survey items
	Inputs	Early Inputs (Independent variable)	Initial high expectations of the PCOs possible contribution Feeling of common purpose across members of PCO Initial feeling of clear overall purpose PCO with sufficient authority to begin Mixed loyalties felt between individual's parent / sponsoring organisation and the new PCO Previous productive working relationships before PCOs
		Team Inputs (independent variable)	Wide range of skills represented on PCO board Time available to participate in PCO board Wide range of professional backgrounds represented on PCO board Wide range of organisations represented on PCO board Size of membership of PCO board Past history of working together with other members Lack of previous involvement in senior management
Partnership working	Processes	Early Processes (independent variable)	Need to build trust Examples of challenging formation of cliques Examples of challenging difficult members Reviewing progress against goals Opinions voiced easily Opinions listened to Opinions acted upon
		Developing Partnership and Team Processes (independent variable)	Agreed specific objectives Consensus on common purpose Open and strong communications Clear leadership – Chair Clear leadership – C.E.O Clear leadership – Others Understanding of the role of CEO Understanding of the roles of others Understanding of the role – others
	Outputs	Early Wins (independent variable)	Clinical governance Developing of primary care services Commissioning of services Joint commission of services Information Management and Technology Health needs assessment Joint provision of new services
		Effectiveness (dependent variable)	Current strong commitment to PCO Good links with health organisations PCO an effective mechanism for partnership with other organisations New initiatives to stimulate further collaboration Substantial progress to build on for a future PCT Good links with social care organisations Board members commonly putting ideas to help the whole PCO and not parent organisation Improvement in PCO stakeholder relations Tightly knit team with common purpose & direction Potential to discover novel, innovative solutions - enhanced
	Outcomes		

Analysis Procedures

The conceptual model was used as an initial framework to operationalize the constructs into items for the survey and to establish face and construct validity. Correlation established the strength and direction between the variables and factor analysis was used to evaluate the construct validity of the conceptual model of the components of effective teams.

The chi-square test of independence was used to determine statistical relationships between each of the five conceptual components of teams and effectiveness. This was first done by testing the null hypothesis, that the two variables are independent of each other. A low significance value (below 0.05) indicates an association between the two variables and the null hypothesis is rejected. Multiple regression, (Hair *et al.*, 1998) built on these initial steps to examine the strength of the relationships between Effectiveness (the dependent variable) and Early Inputs, Team Inputs, Early Processes and Developing Partnership / Team Processes and Early Wins (independent variables). The model tested is summarized in figure 4.

Figure 4
Proposed impacts on perceived team effectiveness



Thus multiple regression was used to establish both the amount of variance in perceived effectiveness that can be explained by the independent variables and the most influential predictor(s) of effectiveness (see Table 4).

The assumptions about the data, including sample size, multicollinearity, outliers and normality (Tabachnick and Fidell, 1996; Pallant, 2001) were met for this data set.

Effectiveness and Team Processes

The supporting content analysis from the interviews highlights the importance for the need of shared understanding of each other board member's roles, and also then to be understood by other external colleagues from the respectively represented different professional groups.

Effectiveness and Early Inputs

The interviews highlighted the importance of clear agreed purpose between PCO board members within the context of a clear sense of purpose felt by key actors across agencies. Potential conflicting loyalties were identified as possible significant inhibitors of partnership. High expectations for the contribution of PCGs, from national government and individual members (particularly those previously poorly represented groups in primary care management) were identified.

Effectiveness and Team Inputs

The content analysis of the interview data confirmed the frequency analysis of the survey data, as regards the perceived importance of the size, breadth and mix of membership of the new PCG boards as good and key inputs to help promote partnership. The issue of a lack of time available to board members to commit to the work of the new boards by interviewees confers with the frequency analysis from the survey data as a possible factor inhibiting partnership.

What are the Team Working Outcomes of PCGs?

The team working outcomes can be read as clear leadership and consensus of common purpose from this part of the analysis. Equally, without such clarity of leadership and agreement on overall purpose, it is argued that partnership working would be inhibited.

The Influences of Perceived Effectiveness

Table 5 shows that the total conceptual model explains almost 65% of the variance of effectiveness and identifies all significant survey items.

Table 5

Regression Analysis: The Impact of Team Variables on Effectiveness

R	R ²	Adjusted R ²	ANOVA significance	
.804	.646	.600	0.000	
Ranked unique contributors:			Beta	Sig.
Opinions acted upon			.197	.001
Joint provision of new services			.158	.001
Commissioning of services			.149	.001
Health needs assessment			.121	.008
Past history of working with other PCOs/members			-.105	.009
Lack of previous involvement in senior management			-.098	.016
Consensus on common purpose			.113	.018
Clear leadership – CEO			.133	.023
Sufficient authority at the beginning			.094	.030
Developing primary care services			.098	.035

The results support the overall conceptual model proposed in this study with the possible exception of the role that team inputs play in contributing to understanding the effectiveness of a HOF, such as a PCO (see figure 5).

Figure 5

Impact of the Components of Team-working on Perceived Effectiveness

Team-Working Component	Beta	Output
Early Inputs	0.152	Perceived Effectiveness
Team Inputs	-0.093	
Early processes	0.139	
Partnership and Team processes	0.328	
Early Wins	0.428	

The diagram shows five arrows pointing from the 'Team-Working Component' column to the 'Output' column. The arrows originate from the right side of each component's row and point towards the 'Perceived Effectiveness' text in the 'Output' column. The arrows for 'Early Inputs', 'Team Inputs', and 'Early processes' are relatively horizontal, while the arrows for 'Partnership and Team processes' and 'Early Wins' are more angled upwards.

DISCUSSION

Influencing Effective Partnerships

Early Wins have a significant impact on effectiveness, and indeed the strongest and clearest statistical relationship when contrasted with the relationships with the other composite independent variables. It is argued that the joint provision of new services, development of primary care services and the commissioning of services have a particular impact on a PCG board's perceived effectiveness.

Early Processes have considerable impact effectiveness. It is therefore argued that this group of early processes are key in promoting partnership working within the early development of a PCG board. In particular, the survey data demonstrate that when all board members are listened to and included in decision-making, and review of progress against set goals is done, then this has a particular significance when developing effective partnership working across these new hybrid organisations.

Developing Team Processes has a significant impact on effectiveness.

It is clear that this group of items within the composite independent variable made a significant contribution to increasing effectiveness within these hybrid organisations, and particularly the exercise of clear leadership and the development of a clear consensus within the board to its purpose.

The results Early Inputs as a composite independent variable has some impact on, and a link to the dependent variable effectiveness. The factors present at the start of the development of a PCO impact significantly on the promotion of partnership, and are important in understanding an effective collaborative alliance.

Team Inputs thus have a limited impact on effectiveness. This weak statistical relationship was a surprising finding from the research and warrants further exploration. However, the wide range of skills of board members and, perhaps more surprisingly, a lack of previous involvement in senior management do make significant contributions to effectiveness.

Important Inputs when beginning Partnerships

From both frequency analysis (of the survey data) and content analysis (of the interview data), inhibitors to promoting partnership from the inception of PCOs were identified as arising from respondents and colleagues feeling mixed loyalties between the new PCO and their existing parent organisations and also having a lack of time to pursue PCO activities. The data substantiates the particular challenges in creating a new HOF, consisting of a partnership between very different types of organisations. These findings concur with those from the strategic alliance of competitive firms literature. Here Child and Faulkner (1998) emphasize the role of the general manager trying to develop and maintain an effective strategic alliance and while being faced with often many partners with different motives and levels of commitment. In the human services literature for strategic alliances the strong personal commitment of individuals to the alliance is emphasized as vital (Bailey and Koney, 2000). The assumption here is that such committed members have the propensity to make time for the alliance despite still being part of their parent organisation, even if the parent or in this case the system owner (the Department of Health) does not make sufficient

time formally available. In the organisational psychology (including team dynamics) literature a lack of time to communicate and participate and having split management and different parents / paymasters (West and Slater, 1996) is highlighted as influential in inhibiting team work and impairing partnership working. Therefore the issue, of sufficient time to pursue PCO board activities was felt as a pressing one. This lack of the important resource of time was still an issue for English PCOs in the period following the data collection of this study (Wilkin *et al.*, 2002).

From both sources of data in the present study (the frequency analysis of the survey and the content analysis of the interviews), the main promoters of partnership at the outset of the new organisations were the breadth of skills, professions and parent organisations represented within the PCO board / executive committee and the feeling of common purpose and high expectation expressed by respondents. A feeling of common purpose in multidisciplinary health teams is necessary if specific common goals and objectives are to be designed by the team (Øvretveit, 1986). Common purpose across the stakeholders of local agencies and the community is identified by advocates and researchers of whole systems if co-evolving organisations are to develop and emerge in a locality (Pratt *et al.*, 1998). Furthermore, findings from the multiple regression analysis of the present survey data demonstrated that Early Inputs to a board / executive committee were important if the PCO is to be effective in its early and subsequent life. This concurs with the casual systems model of team effectiveness developed by Poulton and West (1997). The specific Early Inputs that make an immediate contribution to Effectiveness (and therefore help to promote partnership working) are identified as sufficient authority for the PCO to begin to address its role, and a clear view of common purpose which individual members bring to the start of their work with the board. The strategic alliance literature makes it plain that active political support from the individual parent organisations is necessary for a successful alliance (Spekman *et al.*; 1998, Weiner *et al.* 2000, Judge and Ryman, 2001).

Within the conceptual model adopted for application and testing, the fairly weak relationship between the independent composite variable, Team Inputs and the dependent variable Effectiveness implies that the model in this respect could be further developed. A stronger relationship was noted between the composite independent variable - Early Inputs and Effectiveness.

Processes within Partnerships

From both the frequency analysis and multiple regression analysis of the present study data it was clear that partnership working was being promoted by recognition of respondents' individual contributions. These contributions were listened to and acted upon by other colleagues including the Chair and CEO. This conclusion is reinforced with data from the earlier interviews demonstrating the inclusive nature of membership when boards were being established. The literature on the dynamics of teams lends support to these particular promoters of healthy teams (Guzzo and Shea, 1992; Poulton and West, 1997). It is argued here that this helped to build up trust across the new boards. A major parallel longitudinal study of PCOs in the period 1999- 2002 (Wilkin *et al.* 2002) highlighted this inclusive approach to board members taken by formal leaders of PCOs (Chairs and CEOs). However, there was some concern demonstrated in the interviews for this study regarding GPs discussing issues outside the board and the danger of cliques being created and sustained. The importance of challenging cliques is a key issue if a strategic alliance or partnership is to be successful (Child and Faulkner, 1998).

The willingness (evident in the survey) to review progress against agreed goals appears to be a vital process in promoting partnership and is confirmed by the multiple regression analysis. Both the strategic alliance (Segil, 1998) and the organisational psychology literature (West and Slater, 1996) stress the importance of review against agreed objectives as an ingredient for success. The implication is a need to quickly build the PCO board as a team if effective partnership working is to begin to happen, this would include challenging difficult members. If these strategies were not employed then there was evidence from the interview data that some GPs could inhibit partnership working and challenge any premise that all members were equal on the board.

Trust is found to be a key ingredient in developing and sustaining successful teams and strategic alliances between organisations including networks (Powell, 1990; Child and Faulkner, 1998), UK public services (Powell and Exworthy, 2001) and human services in the US (Bailey and Koney, (2000). Child and Faulkner (1998), using the literature primarily from competitive firms, conceived a model relating the three stages in the development of a strategic alliance to three key elements in the evolution of trust between individuals from the different partners in the alliance (see Figure 6).

Figure 6
Alliance Development and the Evolution of Trust

Phase of alliance development over time	FORMATION →	IMPLEMENTATION →	EVOLUTION
	CALCULATION	MUTUAL UNDERSTANDING	BONDING
	Pilot study (April 1999)	Survey (April 2001)	
Key element in trust development	‘Being to prepared to work with you’	‘Getting to know about you’	‘Coming to identify with you as a person’

Source: Adapted from Child and Faulkner (1998)

The stages of trust development in relation to PCOs across the study have been mapped onto this model in Figure 6. In the period of formation of the alliance, the interviews from the pilot study did pick up issues related to the element of trust denoted by Child and Faulkner (1998) as ‘being prepared to work with you’.

The data from the survey and the independent variables, Early Processes, and Developing Partnership and Team Processes, could be seen as positive indications that the second phase of alliance development in Child and Faulkner's model was perceived as happening by board members i.e. a sense of mutual understanding, perhaps a key element here being “Getting to know about you”.

The findings from the multiple regression analysis also demonstrate the key role that formal leaders play in working with these often diffuse groups (in terms of professional and organisational backgrounds) and converting them into tightly-knit and focused teams.

Team Effectiveness of PCOs

The content analysis of the interview data drew attention to particular roles which needed further clarification i.e. the lay representative and nurse PCG board members. One of the major evaluations of PCGs running parallel to this study (Smith *et al.* 2000) reported the marginalisation of some lay members in the period of set up and also some exclusion from issues on the more medical matters of PCGs. The enormous challenge of creating shared aims and objectives across such a varied cross-section of organisations and interests was made a prominent point within the interviews. This perhaps underlines the difficulty in prompting the co-evolution of and between organisations represented on the then new PCGs, if the goal of creating whole systems was to be pursued (Pratt *et al.* 1998). The previous very mixed record of effectiveness of primary health care teams suggested the difficulty of this challenge in a very similar context (West and Slater, 1996).

The frequency analysis (of the survey data) revealed that respondents placed a very high importance (in respect to early team working outcomes from the new boards) on the agreement on common purpose and specific objectives, clear leadership from the formal PCO leaders (both Chairs and CEOs), open and strong communications across the new boards, and clear understanding of others board roles.

The findings regarding a perceived feeling of clear understanding of roles tie in with the literature in terms of necessary conditions for effective inter-professional working and resulting integrated teams. Rushmer and Pallis (2003) concluded that, where inter-professional working was researched and / or supported, there was a need to establish and maintain boundaries and understand respective roles and avoid misleading attempts and unintentional drift towards unhelpful blurred boundaries (e.g. role uncertainty and ambiguity). The present study highlights that respondents felt many of the results of a drift towards blurred boundaries had been avoided at this stage in the development of each PCO. The avoidance of blurred boundaries may have been addressed by the clear leadership of the CEO and Chair of respective PCOs and also by the board members' contributions themselves.

Within the frequency analysis there was evidence of further team-working outcomes i.e.

- Strong commitment to new PCOs.

- A feeling of teams having developed rather than loose groupings of people thrown together.

- Development of own organisational cultures distinct from that of their constituent/contributing parent organisations.

The implication here was that in terms of initial outcomes from these new hybrid forms there was much positive data indicating that the boards were beginning to work as teams.

Implications for Future Partnership Working?

Enhanced links across local health and social care through the PCG board were evident from the series of interviews. Even from this early data, it was clear that a PCO (with membership across sectors) was recognized by many as needed and that mechanisms and forums existing before 1998 were seen as inadequate to enhance partnership working. Furthermore an increased ability to innovate and undertake new projects was anticipated by these then newly appointed board members.

Early wins

'Early Wins' was a broad category used to capture a series of possible outputs from the PCO of perceived progress of partnership working between the stakeholders represented on the PCO board and not just any internal improved processes of the board as a team. The frequency analysis (of survey data) reported great progress, particularly in addressing clinical governance issues faced by the new PCO, and significant progress for other PCO aims and objectives. These included developing the PCO's primary care services and the commissioning of services by the PCO. The major parallel study, (Wilkin *et al.*,2002) reported similar widely perceived progress from PCO board members as regards clinical governance and developing primary care services but not for commissioning services.

Returning to the present study, there also appeared slower reported progress in issues such as information management and technology, health needs assessment, and the joint provision of services with other agencies. Here, the multiple regression analysis highlighted the clear and positive contribution brought about by the joint provision of new services with other agencies, the development of primary care services, and the commissioning of services, to explain the impact of initial outputs (labelled in this study 'Early wins') had on explaining the variance for the scale of effectiveness devised in the study. The multiple regression analysis also demonstrated the beneficial result of making early wins on how members perceived their PCO's effectiveness. The implication here is that PCO boards / executive committees should recognize the importance of early wins, whether these be setting up new structures and processes or addressing tasks, as a means to further motivate the board / executive committee and therefore stimulate an enhanced ability and capacity to develop improved partnership working.

In the change management literature early wins or successes are underlined as vital in managing strategic change. Quinn (1980) draws attention to the importance of executives ensuring that small successful projects are completed, so creating pockets of commitment and support on the way to more major change (advocating and incremental approach to change). Johnson and Scholes (2002) similarly highlight the importance of visible short-terms wins when initiating progress and maintaining momentum towards longer term strategic change.

REFERENCES

- Bailey, D. and Koney, K.M. (2000) Strategic alliances among health and human services organizations, London: Sage.
- Benson, L.A. (2003) Effective partnership working in hybrid organisations - The impact of partnership working as an antecedent to success in public healthcare, PhD thesis, Bradford: University of Bradford.
- Borys, B. and Jemison, D.B. (1989) 'Hybrid arrangements as strategic alliances: theoretical issues and organizational combinations', Academy of Management Review, 14:2 pp234 – 249.
- Bowling, A. (1997) Research methods in health, Buckingham: Open University Press.
- Bronder, C. and Priztl, R. (1992) 'Developing strategic alliances: A conceptual framework for successful co-operation', European Management Journal, 10:4 pp412 – 421.
- Bryman, A. (2001) Social research methods, Oxford: Oxford University Press.
- Child, J. and Faulkner, D. (1998) Strategies of Co-operation: Managing Alliances, Networks and Joint Ventures, Oxford: Oxford University Press.
- Department of Health, The New NHS Modern, Dependable, (Cm 3807, 1997) London: The Stationery Office.
- Department of Health, Modernising Social Services - Promoting independence, improving protection, raising standards (Cm 4169, 1998a), London: The Stationery Office.
- Department of Health (1998b) The new NHS Modern and Dependable: Establishing Primary Care Groups roles of PCGs, HSC 1998 /065, London: DOH.
- Dillman, D.A. (1978) Mail and telephone surveys: The total design method, New York, Wiley.
- Flynn, R., Williams, G. and Pickard, S. (1996) Markets and networks - contracting in community health services, Buckingham: Open University Press.
- Gerrish, K., Pollard, J. and Ross, B. (1998) 'Integrated nursing teams in Sheffield: the team's perspective', Primary Health Care, 8:8 pp12 – 14.
- Glendinning, C. (2002) 'Partnerships between health and social services: developing a framework for evaluation', Policy and Politics, 30:1 pp115 – 127.
- Gray, B. and Wood, D.J. (1991) Collaborative alliances: Moving from practice to theory, Journal of Applied Behavioral Science, 27 (1), pp. 3-22.

Gulati, R. (1995) 'Does familiarity breed trust? The implications of repeated ties for contractual choice in alliances', Academy of Management Journal, 38:1 pp85 – 112.

Guzzo, R.A. and Shea, G.P. (1992) Group performance and intergroup relations, IN: Dunnette, M.D. and L.M. Hough eds. Handbook of industrial and organizational psychology, 2nd edition, Oxford: Oxford Psychologists Press.

Hackman, J.R. ed. (1990) Groups that work (and those that don't): Creating conditions for effective teamwork, San Francisco: Jossey Bass.

Hair, J.F., Anderson, R.E., Tatham, R.L. and Black, W.C. (1998) Multivariate data analysis, 5th ed., New Jersey: Prentice Hall.

Halverson, P.K., Klazny, A.D. and Young, G.J. (1997) 'Strategic alliances in healthcare: Opportunities for the veterans affairs healthcare system', Hospital and Health Services Administration, 42:3, pp383 – 410.

Hamel, G., Doz, Y.L. and Prahalad, C.K. (1989) 'Collaborate with your own competitors – and win', Harvard Business Review, 67:1 pp133 – 139.

Hamel, G. (1991) 'Competition for competence and inter-partner learning within international strategic alliances', Strategic Management Journal, 12 pp83 – 103.

Harrigan, K. (1988) 'Strategic alliances and partner asymmetries', Management International Review, 28, special issue, pp53 – 72.

Health Act 1999 (c.8) London: The Stationery Office.

Hudson, B., Hardy, B., Henwood, M. and Wistow, G. (1997) Inter-agency collaboration: Final report, Leeds: Nuffield Institute for Health.

Hudson, B. (1999) 'Dismantling the Berlin Wall: developments at the health –social care interface', Social Policy Review, 11 pp187 – 204.

Hudson, B. (2002) 'Interprofessionalism in health and social care: the Achilles' heel of partnership?' Journal of Interprofessional Care, 16:1 pp7 – 17.

Jackson, P. M., and Stainsby, L. (2000) 'Managing public sector networked organizations', Public Money and Management, 20:1 pp11 – 16.

Johnson, G. and Scholes, K. (2002) Exploring Corporate Strategy - Text and Cases, 6th Edition, London: Financial Times - Prentice Hall.

Judge, W.Q. and Ryman, J.A. (2001) 'The shared leadership challenge in strategic alliances: Lessons from the U.S. healthcare industry', The Academy of Management Executive, 15:2 pp71-79.

Kvale, S. (1996) Interviews – an introduction to qualitative research interviewing, London: Sage.

The Labour Party (1995) Renewing the NHS – Labour’s agenda for a healthier Britain – Conference 95, London: The Labour Party.

Le Grand, J., Mays, N and Mulligan, J. (eds) (1998) Learning from the internal market — a review of the evidence, Kings Fund: London.

Lei, D. and Slocum, J.W. (1992) ‘Global strategy, competence building and strategic alliances’, California Management Review, 35:1 pp81 –97.

Ling, T. (2000) Unpacking partnership: the case of health care in Clarke, J., Gerwitz, S. and McLaughlin, E. (eds) New managerialism, new welfare? London: Sage.

Lorange, P., Roos, J. and Bronn, P.S. (1992) ‘Building successful strategic alliances’, Long Range Planning, 25:6 pp10 –17.

Maynard, A. (1998) ‘GP fund holding is dead! : long live the new primary care groups’, British Journal of Health Care Management, 4:10 pp469-471.

Mohr, J. and Spekman, R. (1994) ‘Characteristics of partnership success’, Strategic Management Journal, 15:2 pp135-153.

Ohmae, K. (1989) ‘The global logic of strategic alliances, Harvard Business Review, 67:2 pp143 – 154.

Oliver, C. (1990) Determinants of interorganizational relationships’, The Academy Of Management Review, 15:2 pp241 – 266.

Øvretveit, J. (1996) ‘Five ways to describe a multidisciplinary team’, Journal of Interprofessional Care, 10:2 pp163 - 171.

Øvretveit, J. Planning and managing interprofessional working and teams. (1997) in Øvretveit, J., Mathias, P. and Thompson, T. (eds) Interprofessional working for health and social care, London: Macmillan,.

Pallant. J. (2001) SPSS survival manual, Buckingham: Open University Press.

Parkhe, A. (1991) ‘Interfirm diversity, organisational learning and longevity in global alliances’, Journal of International Business Studies, 22:4 pp579 - 601.

Pearson, and Spencer (1997) Outcome measures for teamwork in primary care in Pearson, P. and Spencer, J. (eds) Promoting teamwork in primary care, London: Arnold.

Poulton, B. and M. West (1997) Defining and measuring effectiveness for primary health care teams in Pearson, P. and Spencer, J. (eds) Promoting teamwork in primary care, London: Arnold.

Powell, M. and Exworthy, M. (2001) ‘Joined-Up solutions to address health inequalities: Analysing policy, process and resource streams’, Public Money and Management, 21:1 pp21 – 26.

Powell, M., Exworthy, M. and Berney, L. (2001) Playing the game of partnership in (eds) Sykes, R., Bochel, C. and Ellison, N., Social Policy Review 13b, Developments and debates: 2000-2001 Bristol: The Polity Press.

Powell, W.W. (1990) 'Neither market nor hierarchy: network forms of organization', Research in Organizational Behavior, 12 pp295 – 336.

Pratt, J., D. Plamping and P. Gordon (1998) Partnership: fit for purpose? – Whole systems thinking – Working Paper Series, London: King's Fund.

Quinn, J.B. (1980) 'Managing Strategic Change', Sloan Management Review, 21:4 pp3-20.

Ranade, W. (1997) A future for the NHS? Health Care in the Millenium, 2nd ed., London: Longman.

Reardon, K. and Spekman, R. (1994) 'Starting out right: negotiation lessons for domestic and cross-cultural business alliances', Business Horizons, January / February, pp71 – 80.

Ring, P. and Van de Ven, A. (1994) 'Developmental processes of cooperative interorganizational relationships', Academy of Management Review, 19:1 pp90 - 118.

Rule, E. and Keown, S. (1998) 'Competencies of high-performing strategic alliances', Strategy and Leadership, 26:4 pp36 – 37.

Rushmer, R. and Pallis, G. (2003) 'Interprofessional working: The wisdom of integrated working and the disaster of blurred boundaries', Public Money and Management, October to December, 23:1 pp59 - 65.

Scottish Office and Department of Health, Designed to care: Renewing the National Health Service in Scotland, (Cm 3811, 1997) The Stationery Office: Edinburgh.

Segil, L. (1998) Strategic Alliances for the 21st century, Strategy and Leadership, 26:4 pp12 – 16.

Shortell, S.M., Bazzoli, G.J., Dubbs, N.L. and Kralovec, P (2000) 'Classifying health networks and systems: Managerial and policy implications', Health Care Management Review, 25:4 pp 9 –17.

Smith, J.A., Regen, E., Goodwin, N., Mcleod, H. and Shapiro, J. (2000) Getting into their stride: Interim report of a national evaluation of primary care groups, Birmingham: Health Services Management Centre – University of Birmingham.

Spekman, R.E., Forbes III, T.M., Isabella, L.A. and MacAvoy, T.C. (1998) 'Alliance management: A view from the past and a look to the future', Journal of Management Studies, 35:5 pp747 – 772.

- Tabachnick, B.G. and Fidell, L.S. (1996) Using Multivariate Statistics. 3rd ed., New York: Harper Collins.
- Teece, D.J. (1992) 'Competition, co-operation and innovation: Organizational arrangements for regimes of rapid technological progress', Journal of Economic Behaviour and Organization, 18 (1), pp 1-25.
- Webster, C. (1998) The National Health Service : a political history, Oxford University Press: Oxford.
- Weiner, B.J., Alexander, J.A. and Zuckerman, H.S. (2000) 'Strategies for effective management participation in community health partnerships', Health Care Management Review, 25 (3), pp 48-66.
- West, M. and Poulton, B. (1997) Primary health care teams: In a league of their own. in Pearson, P. and Spencer, J. (eds) Promoting teamwork in primary care, London: Arnold.
- West, M.A. and J. Slater (1996) Teamworking in primary health care: A review of its effectiveness, London: Health Education Authority.
- Welsh Office, Putting Patients First, (Cm 3841, 1998) Cardiff: The Stationery Office.
- Whipple, J.M. and Frankel, R. (2000) 'Success of strategic alliances', Journal of Supply Chain Management, 36(3), pp 21 – 28.
- Wilkin, D. Coleman, A. Dowling, B. and Smith, K. (2002) National Tracker Survey of Primary Care Groups and Trusts 2001/2002: Taking Responsibility ?, Manchester: National Primary Care Research and Development Centre.