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Evaluating the outcomes of health and social care partnerships: the POET approach

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Abstract

Health and social care partnership working is a central feature of the current government's approach to public policy. Yet despite this, and a proclaimed interest in evidence-based policy, partnerships have not empirically demonstrated that they produce better outcomes for service users. This is problematic because if partnerships are seen to have not delivered, this may result in the concept losing legitimacy in the eyes of the practice community. This paper argues that this may, in fact, be a result of the way in which we have attempted to evaluate partnerships – rather than an indication of the ineffectiveness of partnerships per se. After providing an overview of the various ways in which the 'partnership' label has been used in health and social care, the paper moves on to give an overview of the range of difficulties involved in evaluating partnerships. When it comes to evaluating partnerships the challenge is huge - but not insurmountable – and may involve us asking different kinds of questions about partnerships than have tended to be investigated thus far. The paper then moves on to outline POET (Partnership Outcomes Evaluation Toolkit) which has been specifically designed to determine what kinds of partnership deliver what forms of outcomes, to whom and when.

Keywords: Health and social care, partnerships, evaluation

Introduction

Since the New Labour government came to power in 1997, partnership working stands out as a *leitmotif* of their approach to public policy. Although it has long been recognised that, for particular issues and for certain individuals and communities with complex, cross-cutting needs, the co-operation of a range of agencies might be necessary to address these issues - partnerships have become ever more prevalent over the past decade. A range of policy documents have referred to the importance of health and social care organisations working in partnership (for example, Secretary of State for Health, 2000; Department of Health, 2005a; Secretary of State for Health, 2006) and the government has introduced a range of legal flexibilities (for example, The Health Act 1999) and mechanisms (such as Care Trusts, Children's Trusts, Local Strategic Partnerships, etc.) to encourage public sector organisations to work with others. In recent years, the collaboration agenda has been further extended, beyond health and social care, to education, housing and welfare. Moreover, the most recent health and social care white paper *Our Health, Our Care, Our Say* (Secretary of State for Health, 2006) also indicates the importance of the involvement of commercial and third sector organisations in addressing a number of the key issues which today's society faces. Sullivan and Skelcher (2002, pp. 25-7) estimate that public sector organisations in the UK are involved in approximately 5,500 different partnerships and that these partnerships might have a total annual direct and indirect expenditure of between £15-20 billion. Whilst an estimate, rather than a precise calculation, and one which is now slightly dated, it cannot be in doubt that partnerships have a significant presence within the public sector.

The legislation which established the welfare state in the 1940s assumed that it was possible to distinguish between people

who are sick (that is, those who have health needs which are met by the NHS free at the point of delivery) and those who are frail or disabled (and are viewed as having social care needs, which fall under the remit of local authority social services and are often subject to means-testing for user charges). Despite a range of attempts to overcome this boundary, this underlying distinction still exists and has resulted in two separate agencies with different structures, priorities, financial systems, cultures and ways of working. This boundary continues to exist today and, although to some extent recent policy has become more sophisticated at hiding and blurring this divide, the government recognises that this boundary still causes significant difficulties for service users, particularly those who access services at times of significant stress or illness (Department of Health, 1998). Thus, partnership working has, to some extent, been seen as the mechanism to overcome the organisational complexities which are inherent within the current health and social care structures.

As well as being firmly wedded to the concept of partnership working, the incumbent government has also made extensive reference to the concept of evidence-based policy. Although evidence-based policy and practice is by no means a new phenomenon within health and social care (see Swinkels *et al.*, 2002), the present government has placed a particular emphasis on this concept. The Cabinet Office states in the Magenta Book (official guidance notes for policy evaluation and analysis), that "evidence-based principles are at the heart of the Government's reform agenda for better policy making and policy implementation" (Cabinet Office, 2003, p. 17). Tony Blair himself has stated that "what counts is what works" and the government has been quite clear about its intentions to make policy according to what has been proven to work, rather than on the basis of ideological fiat – as the previous government was critiqued for. Given this dual emphasis on partnerships and evidence-based policy, combined with a recent interest in user outcomes (expressed through such policy documents as HM Treasury, 2003; Department of Health, 2005b; Secretary of State for Health, 2006), it might be expected that partnerships have been empirically demonstrated to improve service user outcomes. Yet a number of evaluations of health and social care partnerships have consistently found little in the way of improved outcomes for those who use services (for example, Peck *et al.*, 2002; Brown *et al.*, 2003; Kharicha *et al.*, 2004; Townsley *et al.*, 2004; Davey *et al.*, 2005). Given the rhetoric about linking partnerships to improved service user outcomes and the central and local efforts that have gone into making a range of partnerships effective, for there still to be a lack of evidence demonstrating their impact for service users might be considered problematic to say the least. Moreover, a range of critical reports about partnerships have served to dent – if not completely destroy – credibility in this concept (see for example, Audit Commission, 2005; O'Hara, 2006; Community Care, 2007) The failure to evidence this way of working runs the risk of it losing legitimacy and professionals becoming disengaged from the partnership agenda.

This paper argues that this lack of evidence in part relates to the scale of the evaluation challenge, rather than a lack of demonstrable evidence *per se*. After defining the term partnership, outlining the scale of the evaluation challenge and the range of critiques which this concept has recently attracted, the paper goes on to provide an approach which is currently being developed and is intended to overcome these evaluative difficulties. The Partnership Outcomes Evaluation Toolkit (POET) is designed to determine what kinds of partnership deliver what forms of outcomes, to whom and when. Furthermore, POET is designed to offer a more nuanced view of the difficulties and challenges

associated with working in partnership and the sorts of support and development mechanisms which are necessary to support and overcome the complexities of working in collaboration.

What is partnership working?

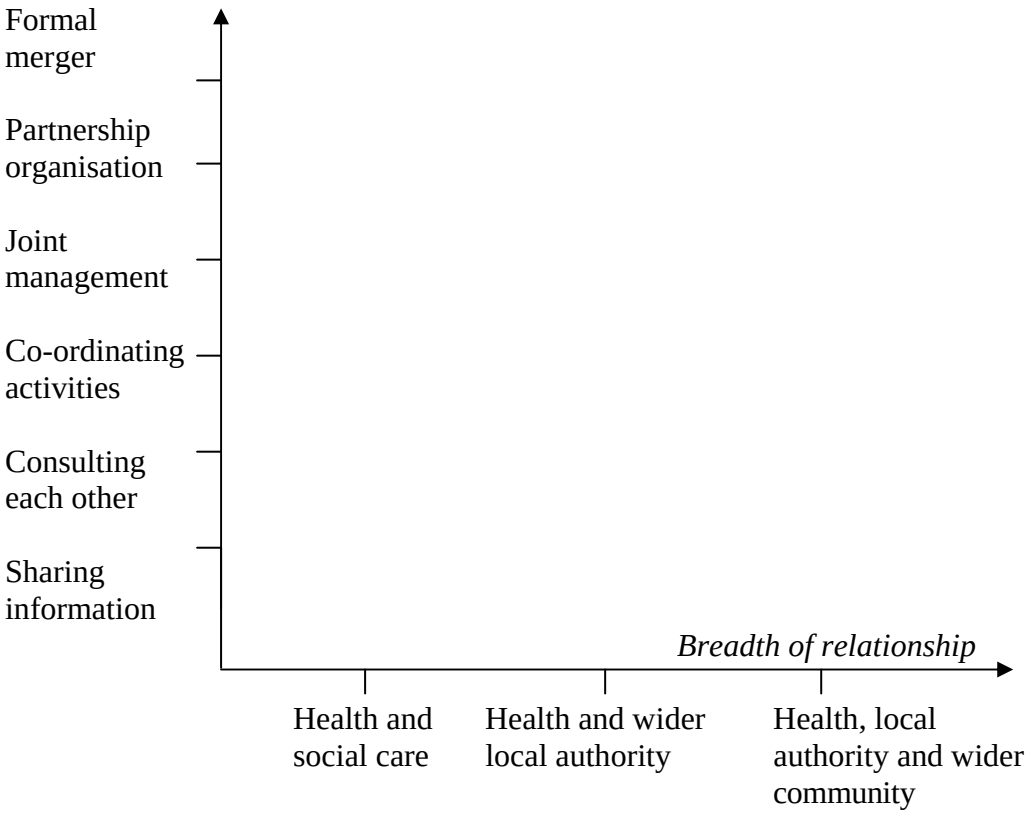
As illustrated above, partnership working is not a new concept and to some extent is a necessary mechanism in order to overcome the structural difficulties associated with the existence of separate health and social care agencies. To this end, partnership is an important concept which aims to bridge the complexities caused by this boundary in terms of policy, practice and services for users. The UK is not alone in affording such a central role to the collaboration concept; in almost every country of the developed world there are problems of fragmentation and a lack of continuity in services for frail older people and other groups with complex, multiple needs (Banks, 2004; Glasby, 2004; Leichsenring & Alaszewski, 2004). Almost irrespective of language, culture, structure, context and funding, within most developed countries there are different services responsible for different aspects of service provision, often with different financial and regulatory systems, roles and responsibilities, and organisational and professional cultures (see Glasby & Dickinson, forthcoming). In pursuit of more joined-up services, a number of models have been developed to promote more seamless care for service users and more effective inter-agency collaboration. Therefore, although partnership is currently a key term within UK public policy, this is a reflection of a much wider phenomenon which is being experienced in many other parts of the world.

The term partnership is used to refer to a range of different forms of relationship or working arrangements within the health and social care arena. Leathard (1993, p. 5) identifies 52 separate terms which have been used to refer to 'partnership', a number of which are often used interchangeably. No wonder then that she goes on to describe partnership as a 'terminological quagmire'. This plethora of terminology and imprecision of usage poses a potential difficulty, in that it can be problematic to establish what particular way of working is being specifically referred to when the term 'partnership' is used. Much of the established literature on inter-organisational relationships tends to suggest there are three ideal forms of relationship between organisations. These are most commonly referred to as markets, hierarchies and networks (Thompson *et al.*, 1991) although Ouchi (1991) speaks of markets, bureaucracies and clans, Bradach and Eccles (1991) of price, authority and trust, and Mayntz (1993) of markets, politics and solidarity. Rodríguez *et al.* (2007, p. 158) characterise these approaches as: rules (hierarchy); incentives (market); and, interactions (network). Each of these ideal types is thought to be optimal for governing interactions between organisations under different conditions and, consequently, each has different characteristics and behaviours. These ideal types are useful in predicting the behaviours of inter-organisational relationships. However, one of the difficulties with the partnership concept, as it has been used within recent health and social care policy, is that it has been used to refer to *all three* of these ideal types of relationship.

For example, we use partnership to refer to Care Trusts (which some would argue are effectively hierarchies), to Private Finance Initiatives (which are arguably market-based relationships) and to clinical networks (which relate more closely, if not entirely, to the ideal network form). Although we know each of these forms as partnerships, they are underpinned by different regulations and behaviours and, as such, we would expect very different outcomes to result from each of these arrangements. Although there are limitations to this idealised tripartite of inter-organisational relationships – and, in

practice, interactions usually exist as a hybrid or as several of these forms over a life-span (see also Lowndes & Skelcher, 1998) - this classification is useful in demonstrating the wide range of different entities known as partnerships within the health and social care arena. As Banks (2002) suggests, this can lead to a number of different forms being grouped together under the same term, when they may, in fact, be different (albeit perhaps only marginally so in some cases). In practice, what this means is that it is difficult to generalise the service user outcomes of partnerships, as partnership has been used to refer to so many different ways of working. Some commentators (see McLaughlin, 2004, for example) have suggested that it is this very lack of definitional clarity over the term partnership that has helped it become so popular. By being relatively broad and encompassing, the answer to any number of potential difficulties could be suggested to be 'partnership', and arguably it has been seen as such an answer in much health and social care policy over the past decade. One framework which is quite useful for characterising typologies of partnership relationships is illustrated in Figure 1. This framework can be employed to establish what types of relationships characterise a partnership and thus which partnerships are similar in nature.

Figure 1: Depth and breadth of partnership relationship (adapted from Peck, 2002)



The evaluation challenge

The range of definitions associated with the partnership concept is one of several evaluation challenges related to this way of working. As suggested above, partnerships may take a number of different forms and tend to be locally implemented, rather than existing in some centrally mandated form. Therefore, it is quite likely that each partnership will have slightly different aims and, consequently, different understandings of what constitutes success for that partnership. Moreover, as Dowling and colleagues (2004) note, the aims of partnerships are often similar to those of other public sector policies (i.e. improved efficiency and effectiveness). Therefore, demonstrating what it is *specifically* that partnerships aim to achieve outside of traditional modes of service delivery is difficult to establish. Thus, there is no single set of outcome indicators which can be used to assess whether a partnership has been successful. Drawing on evidence from the US, Schmitt (2001) suggests what is often missing from evaluations of collaborative efforts is an explanation of *why* certain outcome indicators were selected. In other words, outcome indicators have been selected but it has not been clear what the rationale behind this selection is, or how working in partnership should affect these indicators. As different types of partnership might aim to achieve very different things, it is important that the most appropriate outcome indicators are selected for that partnership – and these may differ from the outcomes another partnership is aiming to impact upon.

Furthermore, partnerships are often comprised of a number of groups who may have quite different perspectives of what it should achieve, and consequently of how the partnership should be evaluated (Thomas & Palfrey, 1996). Not only will different partnerships have different ideas of what counts as 'success', but it is likely that the stakeholders comprising that partnership will vary in their opinion of what success will look like (see Barnes *et al.*, 2005, for an example of this in relation to Health Action Zones). Although partners should have some common goal in terms of the partnership, outside of this initial aim partners will likely have different agendas which they may not necessarily have shared with one another in their entirety. Failure to recognise different concepts of success leads to inappropriate conclusions about the effectiveness of partnerships, and potentially to the inappropriate application of research results (Ouwens *et al.*, 2005). Clearly, this poses a significant evaluation challenge when looking to generalise not only within a partnership but also between partnerships.

The contexts in which different partnerships exist vary widely and impact significantly upon the functioning of partnerships. In terms of learning lessons which may be applied within other contexts in the future, it is important to understand what it is about this context which has facilitated certain types of relationship. McNulty and Ferlie (2002) talk about the importance of 'receptive contexts' in terms of organisational change, and these contexts are similarly important for understanding what it is about certain partnerships which make them effective. As Pollitt (1995) illustrates, what works in one context may not apply within another, and as such it is important to understand the key features of particular contexts for these initiatives. An understanding of context is also important in another key way. Partnerships, like all policy initiatives, exist within broader policy environments which can make it difficult to demonstrate that it is this initiative specifically which has impacted on service user outcomes and not another. Indeed, the issues of attribution and causality are perhaps the largest challenges which partnership evaluations face, particularly given the breadth of outcomes which have been outlined in recent health and social care policy (for example,

Department of Health, 2005b; Secretary of State for Health, 2006). The interim report from the evaluation of Local Strategic Partnerships (LSPs) (Department for Transport, 2005, p. 17) suggests that it is difficult to demonstrate any clear outcomes of LSPs as the chains of causality are extremely complex. As such, the influence of partnership working may be subtle, indirect and cumulative – rather than a direct reflection of a programme. It could further be argued that this issue of attribution has become more complex under the current government, who in the early years of this decade, introduced a plethora of 'initiatives' (e.g. Health Action Zones, Sure Start, New Deal for Communities, Education Action Zones, Children's Fund projects, etc.) which tend to have broadly similar aims and co-exist, often within socio-economically deprived areas.

Part of the difficulty with demonstrating causal links between partnership interventions and service user outcomes may stem from the fact that a number of the outcomes which partnerships are set up to address are often rather long-term in nature. For example, the national Sure Start evaluation (Wiggins *et al.*, 2005) found little in terms of impact of the programme in those areas targeted by the initiative – in fact some children were found to be worse off in the areas targeted by the scheme. There were a range of evaluative difficulties associated with this programme (for example, the population being quite mobile), but one key issue is that of timescales. Many of the targets that Sure Start is set up to achieve are long-ranging and it could be argued that we would not expect to see the real impacts until the children in these areas reach the latter half of their teenage years. There is a substantial difference between expecting to see changes take place within short (more politically acceptable) timescales of say three years in comparison with the 15 years plus which it might actually take to demonstrate change in practice. This poses a significant challenge to partnership evaluations of this type – as it does to the evaluation of other policy initiatives. Moreover, many health and social care partnerships are increasingly being established with a preventative agenda. With the preventative agenda gaining increasing credence within recent policy documents (for example, Secretary of State for Health, 2006) a number of organisations are finding themselves grappling with the issue of how to prove that they have prevented something from happening.

This section has provided an overview of the predominant difficulties which may be encountered when attempting to evaluate partnerships, although, as suggested above, these are not all purely specific to partnerships but are encountered in most evaluations of complex policy initiatives. For the purposes of this paper, these tend to be the main difficulties reported within health and social care partnership evaluations - although there are others (for a detailed examination of the challenges in partnership evaluation see Glendinning, 2002; Dickinson, 2006). Clearly these difficulties are also contingent and will affect some environments more than others. However, what this section aims to illustrate is the scale and complexity of the evaluation challenge. Although, as previously outlined (and covered in more detail below), health and social care partnerships are yet to demonstrate that they appreciably impact on service user outcomes, this may in part be a reflection of the significant evaluation challenge associated with analysing these mechanisms rather than a lack of impact *per se*. This is reflected by Dowling *et al.* (2004) who, in an extensive search of the literature, found that there was little evidence documented about health and social care partnerships affecting service user outcomes and that the majority of partnership evaluations tended to focus on process rather than outcomes. That is, evaluations tend to look at how effectively partners are working together, rather than

whether working in this way necessarily impacts on the outcomes of those services.

This interest in process may partly reflect some tacit but ingrained assumption within the public sector (and evaluators' beliefs) that partnerships lead to better outcomes. Thus, rather than investigating service user outcomes, evaluators analyse the process of partnership working and, if this seems smooth, presume that positive benefits must be produced for service users. There is a fairly well-established literature which examines the main features that are necessary for the process of partnership to be effective (see for example, Wildridge *et al.*, 2004). This evidence is quite useful to draw upon, not least because central government has introduced a number of initiatives (such as the Health Act flexibilities, reorganising PCTs in an attempt to gain greater coterminosity with Local Authority partners) to mitigate the health and social care boundary. However, these have been largely at the structural and legal level as opposed to guidance to local health and social care economies about *actually* producing effective partnerships in practice. Such a view by government presumes that, by demolishing the structural and legal difficulties, local organisations should simply be able to create effective partnerships. When, in practice, as Armistead *et al.* (2007, p. 218) note, "partnerships are often overlain on a palimpsest of previous attempts at collaboration, which may betray a history of inter-organisational, interpersonal or clan conflict". As such, Glasby (2003) argues that three levels are essential in forming effective partnerships; structural, organisational and individual. These levels re-enforce each other, but all require attending to in the attempt to build effective partnerships. Whilst the government has been fairly attentive to questions of structure (such as legal and bureaucratic issues) it has been less so to organisational and individual matters – yet arguably these are the challenges in which local health and social care economies require most support.

A number of partnership 'health assessment' tools, such as the Partnership Assessment Tool (Hardy *et al.*, 2003) and the Working Partnership (Markwell *et al.*, 2003) are available to assist partnerships by assessing the key features of effective 'process' in partnership working. These are generally cheap, quick and cost-effective, whilst designed to be generic and so applicable in a wide range of contexts. Critics have pointed out that, as useful as these tools are, they sidestep the issue of what partnerships might ultimately reasonably be expected to achieve; improved outcomes for welfare users (Rummery, 2002). These tools do not provide a comprehensive framework, and do not make explicit distinctions between inputs, processes and outcomes of successful collaboration (Asthana *et al.*, 2002). Many of these process assessment tools reflect this and point out that they are more useful as developmental aids, rather than as a means of central assessment (Hardy *et al.*, 2003; Halliday *et al.*, 2004).

A further reason for this evaluative focus on process over outcome, could be due to the fact that, as suggested above, actually choosing what outcomes to study is quite a complex task when thinking about multi-agency, multi-stakeholder entities like partnerships. When evaluating partnerships, it is insufficient to think simply of process, with little regard for outcomes; similarly it is insufficient to simply study outcomes with no consideration of the process of partnership working. Without understanding how effectively partners are working together, it will be difficult to know whether the expected outcomes should flow from the partnership. Partnerships are difficult to make work at the best of times (Hudson, 2006) and there are likely to be sticking points, which could potentially influence the impact which the partnership might have on services and, consequently, upon service

user outcomes. Thus, it is imperative that partnership evaluations can encompass both the process and the outcome of partnership working.

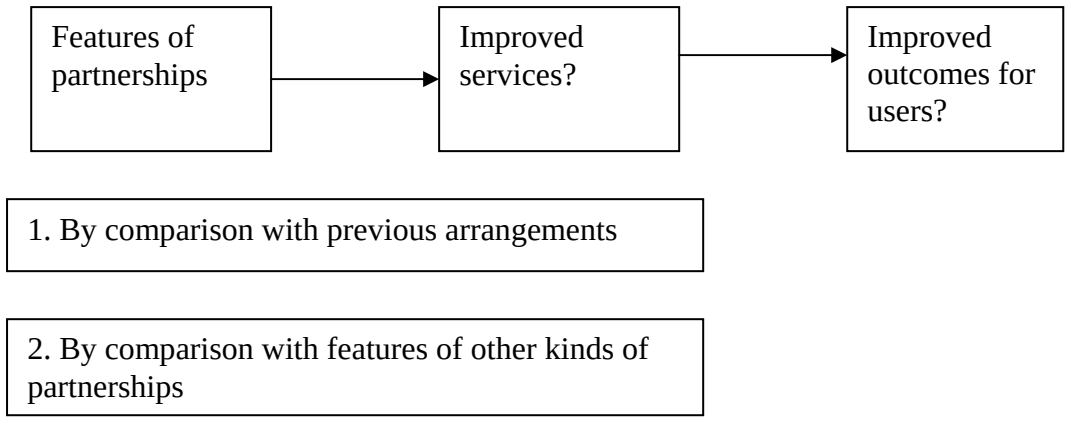
The POET approach to evaluation

The government has expounded much rhetoric around the positive impact which health and social care partnerships should have on service users, but this has not been evidenced and, given the range of difficulties which a number of partnerships are presently experiencing, there is a danger that the concept will lose legitimacy and that front-line workers will no longer be prepared to engage with this agenda. Perhaps then, instead of asking "do partnerships improve outcomes of service users?" it is more appropriate to ask, "which service users do partnerships improve outcomes for, when, where and how?" Glasby *et al.* (2006, p. 373) characterise this question in Figure 2.

The Health Services Management Centre at the University of Birmingham has set up a project to test the question posed in Figure 2, producing the Partnership Outcomes Evaluation Toolkit (POET). POET is a generic toolkit (in that it can be used with a range of health and social care partnerships that fit at different areas in Figure 1) designed to analyse both the process and outcomes of partnerships. This project aims not only to determine what sorts of service user outcomes are produced by different partnerships, but also offer a more nuanced account of how partners might work together more effectively and the sorts of support mechanisms this way of working demands.

As this paper suggests, in attempting to evaluate the outcomes of partnerships, it is insufficient to simply measure outcomes and compare these with previous results or those produced by similar contexts. Given the dynamism and complexity of partnerships as socio-cultural institutions, to only look at outcomes would miss the processes taking place within the 'black-box' of the partnership. With that in mind, POET takes a two-pronged approach consisting firstly of a staff survey and, secondly, of work with service users and carers. It is intended that, by combining these findings, a more rounded view of the partnership process and associated outcomes might be gained.

Figure 2 Effective partnership working (in theory) (Glasby *et al.*, 2006, p. 373)



Staff survey

The first part of the POET approach is to invite all, or at least a representative sample (depending on the size of the partnership), of staff members from all the partner organisations to complete a questionnaire. This part of the toolkit is based online which aids the speed of data collection, and all individuals are given a personalised user name and password which only they have access to. This means that all the information gathered in this survey is anonymous and non-identifiable and early indications show that individuals value this opportunity to be candid about their views. This survey has two distinct aims:

- Based on an extensive literature search on the process of partnership working, the survey aims to test the 'health' of the partnership. That is, this process is similar to the health assessment tools earlier referred to, and highlights the areas partners are working well together in and the areas where some developmental work might be necessary.
- As suggested earlier, partnerships differ in their aims and individual partners may also differ in their concept of what the partnership should achieve. In order to determine what outcomes should be analysed when evaluating a particular partnership, a 'Theories of Change' approach has been built into the staff survey. This theory-led evaluation method originated in the US (Connell *et al.*, 1995) but has recently been used in national evaluations such as the Children's Fund (Barnes *et al.*, 2006), LSPs (ODPM, 2005) and Health Action Zones (Barnes *et al.*, 2005). This approach aims to 'surface' the assumptions held by individuals within the partnership concerning what the partnership is aiming to achieve in terms of service users and carers. In other words, information is gathered from all stakeholders about what success would look like for the partnership.

Once the data from staff members has been gathered and analysed, a 'health of the partnership' report is produced, illustrating staff perspectives of the partnership along with areas for celebration and development. This report also gives an in-depth view into the processes and contexts behind the partnership and how this might influence services provided by the partnership. Furthermore, this stage produces a range of information from all the stakeholders about what the partnership is aiming to achieve in terms of outcomes for those who use its services. Theory-led evaluative approaches are increasingly being used to overcome issues of attribution; this approach unlocks the 'black box', and looks at the processes which go on within the programme rather than simply at the outputs (Robson, 1993). This allows the researcher to then say with confidence which parts of the programme worked and why, whether they would be applicable to different situations and if there are any positive or negative effects which would otherwise not be anticipated (Birckmayer & Weiss, 2000). Rather than inferring causation from the input and outputs of a project, as experimentation does by excluding all other rival causal links, theory-led evaluation aims to map the entire process (Pawson & Tilley, 1997).

Service user and carer research

The second part of the research is very much informed by the first part. Therefore, although this is ostensibly a generic toolkit, it may be used within partnerships with quite different characteristics, but still be valid for that particular context. This part of the evaluation process takes the outcomes which were surfaced in the staff survey and forms a research schedule which:

a. Checks with service users and carers whether these are the 'right' outcomes

that the partnership should be aiming to deliver. Are these what service users and carers value and are there any aspects which are missing?

b. Verifies the extent to which the partnership is delivering on these particular outcomes.

As this process is determined by the context and nature of the partnership, this part of the evaluation process can look rather different from partnership to partnership. However, the outcomes which are expected to flow from partnerships would similarly be expected to vary, depending on the nature of the partnership. The toolkit provides guidance and examples exploring the different ways in which this stage of the evaluation might be carried out, and the kinds of approaches which are most appropriate for particular service user groups.

In this way, POET is both:

- *Formative* - it seeks to evaluate how well partners are working together, helps people to understand and make sense of their current context, and highlights both areas for celebration within the partnership as well as areas where development work is needed. It also allows partnerships to benchmark their performance and check back over a period of time to see if these issues have been resolved.

- *Summative* - POET is evaluative in that it requires partnerships to be explicit about desired outcomes and then analyses the degree to which the partnership is successful in achieving these aims.

POET is currently reaching the end of its initial testing and refinement stage, after which it will be launched nationally in conjunction with the Care Services Improvement Partnership. Although the initial testing is producing a series of key lessons which seem salient across some of these sites, it is hoped that, once launched nationally, a much larger evidence base will be able to be captured. POET has been designed within a critical realist framework (see Dickinson, 2006, for further on the theoretical and philosophical underpinnings) which seeks to search for mechanisms behind observed phenomena. Such an approach acknowledges the complexity of the world, but argues that by using particular techniques, aspects of programmes or policies may be uncovered which tend to behave in particular ways under a set of specific circumstances. In this way, it is anticipated that POET will be able to offer generaliseable lessons about what kinds of partnership are able to produce what sorts of outcomes, for whom, where and when – but also come up with best practice guidance relating to how to make partnerships more effective in practice and some support and development initiatives that might assist this process.

Conclusion

Health and social care partnership working is not a new phenomenon but, over the past decade, has received a particular focus from the New Labour government. Interest in this way of working has largely been predicated on the notion that it will improve services, and consequently outcomes for those who use services. Despite being a central feature of much health and social care policy over this period, and a range of mechanisms and initiatives which have been introduced to encourage and make the process of partnership working more ‘smooth’, there is still a lack of evidence to demonstrate that partnership working improves service user outcomes. Furthermore, in recent years, partnerships have been critiqued for their potential risks, and more recently there have been reports of partnerships coming under significant pressures. Partnership working is an internationally encountered phenomenon, and there are numerous reports from the UK and elsewhere of the damaging effects

which working in organisational silos can have on service users. Yet, a lack of evidence and current difficulties on the ground is leading to a crisis of confidence in this concept, which may lead to staff disengaging with this agenda.

This paper argues that it is the complex nature of partnership working and the scale of the evaluation challenge and the range of associated difficulties which this poses to evaluators which may prove to be the primary difficulty – rather than partnerships having a lack of impact *per se*. Rather than trying to establish whether partnerships lead to improved services for users, we should instead be investigating if partnerships do improve services, who is this for, where, when and how? Partnerships are difficult entities to make work and require much input. Although the government has introduced a series of mechanisms to aid this process, these have tended to be structural and legal fixes, rather than practical advice about how 'to do' partnership. Drawing on previous experiences of partnership evaluation, this toolkit aims to overcome these evaluative difficulties, incorporating both process and outcome evaluations. The POET project aims to offer a more nuanced account of partnership, offering practical advice on the kinds of support mechanisms and development opportunities which aid partnership working and the potential impacts different sorts of partnership might have, moving the debate to a more mature and subtle level concerning the ways in which health and social care services can be improved for the individuals receiving them.

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